State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 04:18 A<sup>M</sup> March 16, 2006 Mary Elizabeth Brown /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner <u>Shady Grove Adventist Hospital</u> Rockville
If Under 1 Year If Under 24 Hrs. Montgomery 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 212 ☐ F Yrs. Director 722-10-9790 12/29/1921 84 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28s-f ehow Examiner must be notified at 1 ☐ Yes 2√XNo Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19224 Circlegate Dr. #204 20874 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2€ No If Yes, Give Year or Dates: 10 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 录No Specify: þ 3€Widowed 4 Divorced "naturel", **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Housekeeper</u> Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mantel Hy Important: If item 27 Is marked oth any injury or other traumatic event <u>once.</u> George Collins Rosa Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19224 Circlegate Dr. #204 Germantown, MD 20874 Sarah Koonce-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2006 Brentwood, MD Fort Lincoln Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln F.H. 3401 Bladensburg Rd. Brentwood, MD 20722 23a. Pany Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximat⊎ Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY FAILURE **Physician** minute /Medical Due to (or as a consequence of): Examiner SEPSIS / week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medicai attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural Injury 5 Pending death. I Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by efter 4 Homicide within 24 hours e To the Funerel D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063129 MARCH 16, 2006 W> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POWLIMI NADKARNI 9901 Medical Center Dr. Rockville, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 7 2006

Box 68760,

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2. Registrar's Signature

	1 - State Registrar	4)		Cer	rtifica	te of L	Death			Reg. No.		1000
ian	1. Decedent's Name (First, Middle, Las Sylvia Ruth Bens								2. Date of De Month	Day	y Year	
cal	4a. Facility Name (If not institution, give				4h Cih	Town or	Location of		Nazch		County of Dea	
ner	Peninsula legiona		1 10	alac	40. Only	Solie	-Luca	/			NICON	
	5. Social Security Number 6. Se	7. Ag	Θ (In yrs.	last birthday)		r 1 Year	If Under 2	4 Hrs.	B. Date of Bir	th Year	9. Bi	rthplace (State or Fore
	578-60-6987	□M XXF	58	Yrs.	Months	Days	Hours	Min.	B. Date of Bir (Month, Da 04/27/	1947	Wasi	hington DC
1	Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Lim
5		~										1X Yes 2
Director	MD Worceste  10e. Street and Number		ocea	n City		p Code				10g, Citi	izen of What C	Country?
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Funeral	11. Marital Status	12. Was Decedent Armed Forces?					spanic Orig	in? (Spec	rfy Yes or No ican, etc.)	)-	14. Race - Am	
	1 ☐ Never Married XX Married	1 Yes 2 XII	No		irres, spe 1 □ Yes		n, mexican, Specify:	Puerto H	ican, etc.)		Black, Wh Specify: Wh:	
d by	3 Widowed 4 Divorced	Year or Dates:			163	2A 140	Specify.				Specify: 1111	
Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced	kind of w	al Occupa ork done d ise retired	lurina most	of working	9	16b. Ki	ind of Business	s/industry
d m	Elementary/Secondary (0-12)	College (1-4or 5	5+)								11 - + - 1	
	17. Father's Name (First, Middle, Last)			Reser	vall	OHITSU		's Name	First, Middle		Hotel	
To Be	Thomas Coll								serini		,	
-	19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailin	ng Addres	s (Street a	and Number	or Rural	Route Numb	er, City o	r Town, State,	Zip Code) 21842
	Robert E. Benson	(spouse)									ean Ci	
	20a. Method of Disposition		20b. F	Place of Dispo	sition (Na	me of other place	9)	Da	te	20c. Lo	ocation - City o	r Town, State
	XIX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			e of H			1	/22/	2006	Silv	er Spr	ing, MD
	21. Signature of Funeral Service Licen	see		22	. Name a	nd Addres	s of Facility	Bur			al Home	
	/ tacqueline	y tak	but					et B	erlin,	MD		
	231. Part1. Enter the disease, or common shock, or hear failure. List only	plications that caused one cause on each li	the deat	h. Do not ente	er the mo	de of dying	g, such as c	ardiac or	respiratory a	rrest,		Approximate Interval Between
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	resulting in death)	Due to (or as	a conseq				_					
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хап	that initiated events resulting in death) Last	c. Mrc2m Due to (or as			ادن الحد	CHENC	7:					YEARS
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icia	in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at			Dectopic p	regnancy oecify)					Month	Day Year
hys	9 Unknown	9□ Unknown								-		
b	Part II. Other significant conditions co	ontributing to death b	ut not res	ulting in the ur	nderlying	cause give	in in Part I.					to the cause of death?
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Completed									24a. Was	osy	24b. Were a	utopsy findings availal completion of cause of
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Be	25. Was case referred to medical examiner?	Un anitali				Lou		of Death	Check only o	one)		
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io io	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Day		28b. Time of Injury	M	28c. Injury Work			ld. Describe l	how injur	y occurred	
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ert	4 Homicide determined	building, et	. (Specif	y)	coi, iacioi	y, onice			City or To	wn, State	)	idiai i lodie i talliber,
O	29a. Certifier 1 Certifying Phy	ysician: To the best	of my kno	wledge, death	occurred	at the tim	e, date and	place, an	d due to the	cause(s)	and manner a	is stated.
ledical		iner: On the basis of and manner sta	examina ited.	tion and/or inv				occurred	at the time,	date and	place, and du	e to the cause(s)
Σ	29b. Signature and title of certifier	1.11			29	c. License	number			29d. Dat	e signed (Mon	nth, Day, Year)
	Jones	124			1	14	509			MY	ACCH 17	1 5000
	30. Name and address of person who compared to the state of the state	completed cause of d	eath (Iten	23a) (Type, I	Print)							~
4	CI To T	170 751	the	- B)	1. 1.		1. A. S	h \	al = /		1	(X & )

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vaar Month **Physician** 2006 7:20 P March 16 Oscar S. Butler /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Ellicott City Ellicott City Nursing & Rehab. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 MM 2□ F North Carolina 1923 238 24 1875 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Catonsville Baltimore Direct 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 23a or United States 21228 6 York Mills Court death v Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Itams ! 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Amed Forces:

1 X Yes 2 \( \text{No}\)

If Yes, Give
Year or Dates: 1943-45 1 Never Married 2 Married 0 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 þ White 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other t other traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Owen Butler Nancy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other train 6 York Mills Court Catonsville, MD 21228 Lorraine M. Butler/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition Pages 1 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of importent: If eny injury or once. Owings Mills, MD Garrison Forest Vet Cem3-21-2006 4 □ Donation 5 □ Other (Specify) M01044 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner thero sclenolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day Por in the past 12 months? 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Docknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2又 No autopsy performed? 2**/**2 No 1 Yes 2 No certificate 26. Place of Death (Check only one Be 25. Was case referred to medical examiner? Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this nours after death.

neral Diractor: After this
filled in by the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pendina 1X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 T Homicide To the Hospitel within 24 hours a To the Funeral C Hospitel [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30641 March 18, 2006

State Registrar 201-109 Back Rivel Neck Road

Baltimore

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pedistrar's Signature

SabapaThi

00-01037	Please	Type or Print in Black Indelible ink.	Ensure All Copies Are Legib
William Charles Bowen		State of Maryland / Department of He	
For		otate of marytanar bepartment of the	saith and montain rygions,

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cal ner	4a. Facility Name (If not institution,	give street and number	)	4b. City, Town, o	or Location		arcii I		ity of Death		
	2051 Thurston Ro			Urbana		0.11		Frede			
	5. Social Security Number 213–31–3869		ge (In yrs. last birthda 15 Yrs.	y) If Under 1 Year Months Days	If Under Hours	Min. Se	Date of Birth (Month, Day, eptembe	r <sup>Year</sup> 24,	9. Birth	nplace (State or Foreign Maryland	
	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limit	
to	Maryland Frede	rick	Urbana							1 □ Yes 2 🗗 🛚	
Oirec	10e. Street and Number			10f. Zip Code			16	0g. Citizen o		untry?	
rai	2051 Thurston R			21704				U.S.			
by Funeral Director	11. Marital Status  1 De Never Married 2 Marrie  3 Widowed 4 Divorced	12. Was Decedent Armed Forces  1 Tyes 2 17 If Yes, Give Year or Dates:	No	8. Was Decedent of H ff Yes, specify Cub			ty Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.  Specify: white			
Completed	15. Decedent's (Specify only highest	grade completed)	(Giv	edent's Usual Occup re kind of work done . DO NOT use retire	oation during mos	st of working		16b. Kind of Business/Industry			
Eo	Elementary/Secondary (0-12)	College (1-4or	5+) Stud		-,			Edu	catio	lon	
To Be C	17. Father's Name (First, Middle, L. William C. Bowe						First, Middle, M		ame)		
-	19a. Informant's Name/Relationshi Carol Bowen - mo			iling Address (Street Thurston						ip Code) <b>704</b>	
	20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		,	position (Name of rematory or other place) et Cemete:		Dat 1/18/20	006	20c. Location		Town, State	
	21. Signature of Funeral Service 1	icensee		22. Name and Addre		ity Star	uffer F				
1	Immediate Cause (Final disease or condition resulting in death)	a ASPHY			ng, such as	cardiac or r	respiratory arre	est,		Approximate Interval Between Onset and Death	
Examiner		b			ig, sucii as	cardiac or r	espiratory arre	ist,		Interval Between	
dicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	s a consequence of):		ig, sucii as	s cardiac or r	espiratory arre	ist,		Interval Between	
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State Registrar

31. Date filed (Month, Day, Year)
MAR 2 0 2006

32. Signistrar's Signature

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1:00 A M MABEL MURDOCK BEALL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LA PLATA GENESIS LA PLATA CENTER CHARLES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 1 F 212-12-2857 87 Yrs. Director MAR.15,1919 WASH., DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits od 2 should be filed within 72 hours after death with the Marylar lith and Mental Hygiene.
27 is marked other than "natural", or itams 23e or 28e-f show treumatic event, the Medical Examinar must be notified at Director CHARLES LA PLATA MARYLAND 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20646 1 MAGNOLIA DRIVE U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN SELF Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ JOHN J. MURDOCK EMMA M. EMCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Heelth Item 27 other tre NORMAN W. BEALL, JR. - SON 13032 PINE GROVE RD., NEWBURG, MD 20664 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) LINCOLN CEMETERY 3-22-06 BRENTWOOD, MD FT. 22. Name and Address of Facility 21. Signature of Furreral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIJEAG **Physician** OBS+RUCTIVE rul mo NARY CHRONIC disease or condition YRS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, sign be Completed 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospitel within 24 hours a To the Funerel I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aftendia D44436 MARCH 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Ashwin J. Patel, MD, 102 Paul Mellon Ct., Ste. 102, Waldorf, MD 20602

32 Registrar's Signature

2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician James Ginn Barnard, Jr. 15, 2006 12:02 a March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 301 Seven Oaks Lane Lothian Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 578-44-3888 Director 19,1934 Washington, Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other than "naturai", or items 23e or 28e-f show traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Directo MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Seven Oaks Lane 20711 death Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1954-56 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Mental or other traumatic event or other traumatic eve Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 painter painting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 James Ginn Barnard Mary Teresa Nehring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 Seven Oaks Ln., Lothian, MD 20711 Gertrude Barnard, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 03-16-2006 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart follow. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCON **Physician** LING MU /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21. No 1 ☐ Yes 2 ☐ No 1 Yes : After this certific funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2 € No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dav 1923 Monch 15, 2006 23a) (Type, Print) 2068 CRAIN HWY. WAIDORF MD. 20601 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7710m75 Fieldson 32. Registrate Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene)

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15-0036	n 72 hours after death with the Maryland	"natural", or iteme 23a or 28a-f show adical Examiner must be notified at	leted by Funeral Director

permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hyglene. Important: If itsm 27 ie marked other then eny injugt greetser fraumatic event, the Mental Informatic events and Informatic events events and Informatic events event

Baltimore, Maryland 212

Examiner burial-transit and Records, P.O. Box 68760 ŏ detached

Division of Vital a Hospital or Attending P 24 hours effer death. • Funere! Diractor: After to 24 hours e To the Within 2 To the

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 6:04 P M 12, AMELIA DREWNIAK **BROWN** MARCH 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 405 BOYD AVE. MONTGOMERY TAKOMA PARK Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 9. Birthplace (State or Foreign Days 1 M 2 XF Months 014-09-4910 85 MAY 25, 1920 MASSACHUSETTS Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No MD. MONTGOMERY TAKOMA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 405 BOYD AVE. 20912 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Com 10 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဥ MICHEL DREWNIAK ANNA MRIJK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AURELIE B. WILBURN/DAUGHTER 27193 NEALE CT., MECHANICSVILLE, MD. 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 3-14-2006 RIVERDALE, MD. 21. Signature of Funeral Service Licanses CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Chambus 23a. Part1. Enter the disease, or complication. If at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) RECURRENT ENDOMETRIAL CANCER 11 YEARS /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC RENAL INSUFFICIENCY 1 Yes 2 XNo DIABETES MELLITUS 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🖫 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ည 1 Yes 2 No 3 DQA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 🕱 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) address of pe 30. Name . 1221 MERCANTILE LA., LARGO, MD. 20774 ANDREW M.D. 31. Date filed (Month 32. Registrar's Signature Year State 2008 5 Registrar

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Physicia	an	Decedent's Name (First, Middle, Last)     Cecilia J.	Backman					2. Date Month	1	Day	Year	3. Time o	
/Medic					41 03	_	1 1 1 1 1 1 1 1		ch			2:10	рм
Examin	er	4a. Facility Name (If not institution, give a Manor Care - Chevy	,		Ch	evy (	r Location of E Lhase				ntgo		
Funeral Director		044-18-5563	7. Age (In	yrs. last birthday) Yrs.	If Unde Months	Days		Min. 8. Date (Mont) May	of Birth h, Day, 10,	Year) 1921		place (State of otry) ecticu	
death with the Maryland oms 23a or 28e-f show	tor	Usual Residence of Decedent		. City, Town or Lo							1	0d. Inside C	ity Limits
with the a or 28e	Director	10e. Street and Number 8700 Jones Mill Re			10f. Z	ip Code			10	g. Citizen of V		ntry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Manth Hygiene. Important: If time 27 is marked other than "natural; or terms 23a or 28e-f show any injury or other traumatic event, the Marchal Examinar main be codified at once.	by Funeral		12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Deci f Yes, sp	edent of H	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes Puerto Rican, etc	or No-	14. Rac Blac			
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12 should h and Men 7 is marke traumatic	၉	Michael Zebrowsk:  19a. Informant's Name/Relationship (Ty Carol A. Rice/ Day	pe, Print)		-		and Number o	ne Type or Aural Aoute A imore,		-		Code)	
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permit. P Departm importar any injur		21. Signature of Funeral Service Licens	on the same	F. 50	ranes 00 Ui	ng Addre	ss con ly sity B	ns Fune	ral Sil	Home I ver Sp	nc.		17
Physician		23a. Part1 Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Advanced	Dementia	er the mo	de of dyir	ng, such as ca	rdiac or respirat	ory arres	st,		Approxima Interval Be Onset and	tween
/Medical Examiner	Iner	Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor										
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r Atten ter deat irector: ire by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str pecify)				28f. Local	tion (Street Town,	et and Numb State)	er or Rur	al Route Nur	nber,
To the Hospitel of within 24 hours aft To the Funeral D completely filled in	edical (	(Check only one)  (Check only one)	ner: On the basis of example and manner stated.	knowledge doubt mination and/or in	vestigatio	n, in my c	ne, date and ; pinion, death	Jace, and anoth	time, dat	te and place,	and due t	tated. o the cause(	s)
	Me	29b. Signature and title of certifier			2		e number 1566			d. Date signe March			
3		30. Name and addres Tperson who co Sunitha Bhogavill:		(Item 23a) (Type, 20-A Eas		opa F	Road, #	230, To	wson	, MD 2	21286		
Sta Registř		31. Date filed (Month, Day, Year)		ignature									

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** March 18, 2006 John Blake Preston 11:45PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 36675 West Lakeland Drive Mechanicsville
If Under 1 Year | If Under 24 Hrs. | 8 St Mary's 9. Birthplace (State or Foreign Country) Virginia 8. Date of Birth (Month, Day, Year) Aug. 7, 1930 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1⊠M 2□F Months Days Hours 75 Director 579-38**-**0627 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show item 27 is marked other then "natural", or Items 23a or 28e-f show other treumatic event. It is Maraleal Examination ust by multified at 1 ☐ Yes 2 No Director St. Mary's Maryland Mechanicsville 10e. Street and Number 10g. Citizen of What Country? 36675 West Lakeland Drive 20659 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 M Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpenters Union 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental . Pages 1 and 2 should be treent of Health and Menta tant: If item 27 is marked John Fredrick Blake Catherine Elizabeth Ameen 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Wieck/Daughter 36675 West Lakeland Drive, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or Charles Memorial Gar. 3/23/2006 Leonardtown, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Brinsfield Echols Funeral Home P.A. 128, Charlotte Hall, Maryland 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cruse (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) Ö the 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð sign. Probably 4 Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1□ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 😾 No 2 funeral 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospitel or Attending 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mappiner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hausaui 2005-6949 20106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KAKSHI BAIC CRAIN HWY, STEIDZ, LAPLATA. 6620 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 DHMH 17 Rev 1/2001

**ORIGINAL** 

		J.	1 - For State Registrar	State of	Marylan				lealth a Death		fental I	Hygiene Reg. No	000	10010
,	<b>D</b>		1. Decedent's Name (First, Middle, Las	$\supset$							2. Date of Month	f Death Da	ıy Year	3. Time of Death
	Physici /Medio		JOHN D.	BERN	D						Marc			10:30 a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give		ber)		4b. City	, Town, o	r Location o	of Death		40	:. County of Dea	th
	g -	3-	39666 Cecil Ave		//-	to a birati de di		onaro	ltown If Under	24 Ura		( 6: 4)	St. Mar	
	Funeral			M 2□F	. Age (In yrs.		Months		Hours	Min.		Day, Year,	)   G	thplace (State or Foreign ountry)
le "	Director		Usual Residence of Decedent			83 Yrs.					July	1, 19	ZZ Was	hington, DC
	land ow		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					-		10d. Inside City Limits
	Man	ţċ	MD St. Mar	y's	L	eonardt	own							1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Z	p Code				10g. Ci	itizen of What C	ountry?
	filed within 72 hours after death with the Maryland Hyglene. ther then "natural", or Items 23a or 28a-1 ehow ther, the Mudical Exantral arrival te multiled at	a	39666 Cecil Avenu	.e				206	50			Un	ited St	ates
	dea dea	Funeral	11. Marital Status	12. Was Deced		l.S. 13. \	Vas Deci	edent of H	lispanic Ori an, Mexican	igin? (Spi	ecify Yes o Rican, etc.	No-	14. Race - Ami Black, Whi	
36	or it		1 Never Married 2 Married	1 Yes 2 If Yes, Give				2 No	Specify:				Specify:	
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an	id be ental ked o	To Be	John Henry Bernd						Ann	ie L	ouise	Flet	cher	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Wadical Examinar must be rightled at	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailir	g Addres	s (Street	and Numbe	er or Run	al Route Nu	ımber, Cify	or Town, State,	Zip Code)
	s 1 and 2 should Health and Men itsm 27 is marke other traumatic		Loretta Irene Ber	nd/Wife		39666	Cec	il A	venue	. Le	onard	town.	Maryla:	ad 20650
Baltimore,			20a. Method of Disposition  1 Burial 2 Cremation 3	Dames al from C		Place of Dispo	sition (Na	me of	-	- [	Date	20c. L	ocation - City or	Town, State
Ĕ	permit. Pages Department of important: if its eny injury or o		4 Donation 5 Other (Specify			tional							ls Churc	
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m —	89789		Kyye Simons K	01206	-	22	955	Ho11	ywood	Roa	d, Le	onard	town, M	20650
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ě	Physician		Immediate Cause (Final disease or condition	Cor	mm	1 mil	M	Pi.	sen	(				Onset and Death
	/Medical Examiner		resulting in death)	Due to (o	ras a conseq	uence of):	1	11	,	,				
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×	eath certifii attending p for use as	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									23d. Date of de	livery
Box	death certifi e attending I id for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregna	th 2∏Feta ntattime of d		Ectopic   Other (s	pecify) _	У				Month	Day Year
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Ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Deatl	(Check or			
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ב	ding Physiclan: h. After this certific funeral director,	ü	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of (Month	Injury , <i>Day Year</i> )	28b. Time of fnjury	1	28c. Injur Wor			28d. Descr	ibe how inju	ary occurred	
Division of Vital	tend death tor: / the fi	catl	2 Accident investigation 3 Suicide 6 Could not be	-			М		Yes 2 🗆	No				
$\leq$	i or Attendater deati Director:	Certification:	4 Homicide determined	288. Place C	of Injury - At h g, etc. <i>(Specil</i>	ome, farm, str fy)	eet, facto	ry, office				on (Street a Town, Stat		lural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier Certifying Ph	veician: To the b	act of my ba	awledge dest		d at the f	ma data	d place	and due to	the easter	and marror	e stated
	24 hg Fun etely	edical	(Check only 2 Medical Examone)	iner: On the bas	sis of examina	ation and/or in	estigatio	n, in my o	ppinion, dea	id place, ith occurr	ed at the ti	me, date an	s) and manner a id place, and du	e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	01.	<u> </u>		25	c. Licens	e number			29d. Da	ate signed (Mon	th, Dey, Year)
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			30. Name and address of person who o	completed cause	of death (Iter	n 23a) (Type,								
			FIRODZEH H. SH	HHEDI				ESI	SITE	202	FA	usc	HURCH	VA 22046
$\tilde{t}_{ij}$	Sta		31. Date filed (Month PAR 2 2	2006 32.	gistrar's Signa	ature					-			
1	Registi	rar	11 1 14 14 1		TO STATE OF	ZP A								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 10b per FH G856,06/30/06dhb

State of Maryland / Department of Health and Mental Hydiene Amend Item 26 per verb., G855 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Donna Lou Blair March 7, 2006 6:24 a.m. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Mary's Great Mills 21724 Garfield Street If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 06-17-1931 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 🕱 F 74 Yrs. Washington. 435-42-8971 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 XYes 2 No Great Falls MD St. Mary's Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21724 Garfield St 20634 itams 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after dial Hygiene.
other than "natural", or itam 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Arbitron Telecommunications other t 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event 2008. Be Joseph R. Mena ပ္ Luella Ortego 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Luanne Eisenhardt--Daughter 17288 Crab Pot Lane Piney Point, MD 20674 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Memorial Gardens 3-11-06 Norfolk, VA 22. Name and Address of Facility Woodlawn Funeral Home 6329 Va Beach Blvd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final netastatie **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine ed by the ettending physician and detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à certificate has been signi rector, page 2 should be 1 Yes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 25. Was case relerred to medical examiner? 26. Place of Death Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 28I. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funerei C To the Hospital 1 Vertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40055751 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jennifer Schmidt, D.O., 23415 Three Notch Road, California, Maryland 20619

DHMH 17 Rev 1/2001

State

Registrar

31. Date liled (Month, Day, Year)

MAR 2 2 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

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			1 - For State Registrar	Otate of Ivit	zi ytaria / L		tificate of I			Reg. No.	U	10016
			Decedent's Name (First, Middle)	Last)					2. Date of Dea	ith		3. Time of Death
Н	Physici		Joshua	Ryan	Ве	ard	en		March	12 200	Year	00:41 A M
}	/Medio Examin		4a. Fecility Name (If not institution,	give street and number)			4b. City, Town, or	Location of Death		4c. County o		301,12,1
			Baltimore-Washi	ngton Medica	1 Cente	er	Glen Bur	mie		AnnE A	runde	1
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year) 9, 1986 1	9. Birthpla	ce (State or Foreign
и	Director		426-57-0555	1 <b>XX</b> M 2□ F	19	Yrs.			Oct. 29	1986	Missi	ssippi
	bus *		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Lo	cation				100	d. Inside City Limits
	faryla eho	5		Arundel	Oden							1 ☐ Yes 2 ₩ No
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	with a or	ă	613 Fellowship	Way			2111	3		USA	iat Counti	y :
	Jeeth	era	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. V			pecify Yes or No-		- Americar	n Indian,
·^	fer o	F	1X Never Married 2 Marrie	Armed Forces?		l l	Vas Decedent of H i Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Black	, White, et	
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21215-0036	within 72 hours after deeth with the Maryland ene. then "naturat", or iteme 23e or 28e-f ehow he Medical Examinar must be multiled at	Completed by Funeral Director	15. Decedent' (Specify only highest	s Education	16a.	Deced	lent's Usual Occup- kind of work done	ation	rkina	16b. Kind of Bus	iness/Indu	stry
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ב	be fi	Be	17. Father's Name (First, Middle, L Unknown	ast)					ne <i>(First, Middle,</i> .a Handso	Maiden Sumame	)	
3	Mer Merke Marke	2			1							
Maryland	12 st h and 7 le n treun		19a. Informant's Name/Relationsh Virginia Pascua				g Address (Street a Box 1781					
	1 and Heelt em 2 ther		20a. Method of Disposition	(Mochel)					Date	20c. Location - C		
Baltimore,	ages nt of t: if it		1 ☐ Burial 2 ☐ Cremation		{		sition (Name of natory or other place	1				
₽	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "naturat", or iteme 23a or 28e-1 show eny injury or other treumatic event, the Medical Examinar must be multied at once.	1 7	4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Septice L		Metro	-	ematory . Name and Addres		i–2006	Baltimo	re, M	D
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	Physician		shock, or heart failure. List of Immediate Cause (Final	inly one cause on each in			A viol					nterval Between Onset and Death
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		-5	IF FEMALE:							g.	ŀ	
9	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 🗌 Fetal death		Ectopic pregnancy			23d. Date Mont		ay Year
P.O. Box	Attanding Physicien: The law requires that the death or death. r death. ector: After this certificate has been signed by the ettendir by the funeral director, paga 2 should be detached for use	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of death	5	Other (specify)					-,
	that the	P	Part II. Other significant condition	s contributing to death be	ut not resulting i	n the ur	nderlying cause give	an in Part I.	23e, Did to	bacco use contrib	oute to the	cause of death?
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<u> </u>	r Atte ar de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		ry · At home, fa		et, factory, office		28f Location (S	treat and Number	or Bural B	
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	To the Hospital or Attending Ph within 24 hours eftar death. To the Funeral Director: After th completely filled in by the funeral	edicai	(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of	examination an	death	occurred at the timestigation, in my or	ne, date and place pinion, death occu	, and due to the or	ause(s) and man	ner as stat	ed. he cause(s)
	thin 2 the othe	Med	29b. Signature and title of certifier	and manner sta	ted.		29c. License	number		29d. Date signed	(Month De	av Voar)
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7			30. Name and address of person v		aath (Itam 23a)	(Type !	O.C.M	. Ľ.	[Y	larch 12,	2006	)
			LING LI,				enn Stree	t, Balti	more. Ma	ryland 2	1201	
	Sta	te	31. Date filed (Month, Day, Year)	20. 20. 1. /	Ø			-,	,			
4	Registr	ar	MAR	1 6 2006 Hegiste	Teller 1	15	(And)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month March 15, 2006 5:30 Harry N. Breeden 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Crofton Crofton Convalescent Center Il Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days XXM 2 F Maryland 10/14/1929 76 220-24-9048 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Maryland | Anne Arundel Crofton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1408 Knightsbridge Turn 21114 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Amed Forest 1 XYes 2 08/1951-If Yes, Give Year or Dates: 11/1951 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Space Analyst 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen Schiflet Samuel L. Breeden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1408 Knightsbridge Turn Crofton, MD 21114 Jayne D. Breeden/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland
Veterans Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/20/2006 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Tai Due to (6) 52051 Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably

**Physician** /Medical Examiner

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ettending physicien

Physician

/Medical

**Examiner** 

Completed by Funeral Director

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Physician/Medical

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Certification:

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel; or items 23a or 28a-f ehow any nighty or other traumatic event, the Madical Examinating the notified at once.

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

Hospital or Attending Physician: 44 hours efter death. Funers! Director: After this certifice

To the Mospital within 24 hours e To the Funeral I completely filled

filled in by the

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE:

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

_	bru		1	A	ccider

24a. Was an

autopsy 1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other: 41 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

Natural

2 Accident

4 Homicide

3 Suicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certific

6 Could not be determined

29c. License number

Gambr

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print) 1438 Det on 12

31. Date liled (Month, Day, Year) 32. Registrar's Signature

State Registrar 1.80,000

State of Maryland / Department of Health and Mental Hygiene 🛭 🦯 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH **Physician** 14, 2006 12:50P M MAGNOLIA ELIZABETH WILSON BYRD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CHARLES CIVISTA MEDICAL CENTER LA PLATA Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 1937 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 M 2 F WASHINGTON, D.C. 69 Director 217-32-2278 Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10b. County 10a State I7 is marked other then "naturel", or liems 23a or 28e-f ehow traumatic event, the Madical Examinat must be notified at 1 ☐ Yes 2 ▼ No Director MARYLAND CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20640 UNITED STATES 5325 SMITH DRIVE Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. e filed within 72 hours after of Hygiene. other then "naturel", or Iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK δ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Coltege (1-4or 5+) mentary/Secondary (0-12) CUSTODIAN 12TH GRADE PRIVATE permit. Pages 1 end 2 should be filed.
Department of Health and Mentel Hygis important: if item 27 is marked other any Injury or other trauments. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be EMMA LINE GAINES WILSON RICHARD WILSON, SR. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5325 SMITH DRIVE, INDIAN HEAD, MARYLAND CYNTHIA M. BLAND / DAUGHTER 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OAK GROVE CHURCH CEM. MARCH 24,2006 NANJEMOY, MARYLAND 21. San ture of Funeral Service Ocens do THORNION FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON MO0583 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratory arrest

Due to (or as a consequence of): **Physician** /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner physicien end the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Dermato myositis. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed ypertension 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 110 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death [Check only one] Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 PVOutpatient 3 DOA ို 28a. Dale of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending death. 1 Yes 2 No investigation 2 Accident Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 @ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier eted cause of death (Item 23a) (Type, Print) 1220 A East Joppa Rd Towson, MD 21286 31. Date tited (Month State Registrar

			1 - For State Registrar	State of Marylar			of Health and of Death	d Men		iene	16	10015
1 8 A	Physici /Medio		1. Decedent's Name (First, Middle, Las. MARY THE	RESA AFA	HNMI	BAY	IELLE		Date of Dear Month	Day 27	2006	3. Time of Death  21 - 10 AM
	Examir	ner 	4a. Facility Name (If not institution, give UNIVERSITY OF	MARYLAND		BA	vn, or Location of Di	RE			ty of Death	
*	Funeral Director		Social Security Number     Social Security Number	7. Age (In yrs.	Yrs.			Ain. (	Date of Birth Month, Day ar. 22	Year) 2006	Count	ace (State or Foreign rry) rland
	72 hours after death with the Maryland Instural, or Items 23a or 28s-f show dical Examilmer must be molified at	ector	10a. State 10b. County Maryland Carroll 10e. Street and Number		y, Town or Lo		do			0g. Citizen o		od. Inside City Limits 1 X Yes 2 □ No
	sath with	erai Dir	15 Courier Drive	12. Was Decedent Ever in U	S 12 1		21787			United		S
9600	nours after de urai', or item	d by Funeral Director	11. Marital Status  1 💢 Never Married 2 🗆 Married  3 🗆 Widowed 4 🗀 Divorced	Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		1□Yes 2【X		uerto Ricai	n, etc.)	Spec	ack, White, e	etc. Ck
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be notified at anore.	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use r	one during most of	working		no∩e	Business/Ind	lustry
Baltimore, Maryland	ould be file Mental Hy arked oth	To Be (	17. Father's Name (First, Middle, Last) Gideon Bayelle				18. Mother's Eveli	ne A	ya			
, Mar	and 2 shu ealth and m 27 is m		19a. Informant's Name/Relationship (T Gideori Bayelle /	father	15 (	Courier		Tane	ytown,	, Mary	land	21787
imore	Pages 1 ment of H ant: if itel lury or oth		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	emetery, crei	sition (Name on natory or other other)	<sup>r place)</sup>   Ma metery	erch :	31		own, M	<sub>wn, State</sub> aryland
Ball	Departiment Departiment important in portant		21. Signature of Funeral Service Licens	Turon	1:	36 East	Baltimor	e St	reet			Md. 21787
10000000000000000000000000000000000000	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. EXTREM  Due to (or as a consec	E P	REMA	TURITY					Approximate Interval Between Onset and Death
8760,	ite be executed sysicien and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. EXTREM Due to (or as a consect  C. INTRA V Due to (or as a consect  d	uence of): /ENTR	LOW	BIRTH IR HET		EIGHT RHAG			
P.O. Box 6	that the death certifics ed by the attending ph detached for use as t	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	ildeath 3□	Ectopic pregr Other (specif					eate of deliver	ry Day Year
	w requires that t been signed by should be detac	b	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	ndertying caus	e given in Part I.			bacco use co		e cause of death?
Division of Vital Records,	ysician: The law requ is certificate hes been director, page 2 should	Completed						-	24a. Was a autops perform 1 Yes	SV	prior to con death?	osy findings available inpletion of cause of
<u> </u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Other:		Charles Section			
ion of	Attending Physician: or death. ector: After this certifics by the funeral director;	ation: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		4 ☐ Nursin Injury at Work? 1 ☐ Yes 2 ☐ No			ence 6 Co ow injury occ		)
Divis	i 및 ft o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specin	ome, farm, str	eet, factory, of	fice		Location (Si City or Town		nber or Rura	Route Number,
	To the Hospital within 24 hours a To the Funaral I completely filled	edical	29a Certifier 112 ertifying Ph (Check only one) 2 Medical Exam	iner: On the best of my kn, iner: On the basis of examina and manner stated.	wledge datil ition and/or in	n conumed at to vestigation, in	he time, date and pl my opinion, death o	accurred at	dua to the c t the time, d	ane(s) and are and place	nannar as st a, and due to	the cause(s)
)	To the within 2 To the complete	Σ	29b. Signature and title of certifier				cense number P1877	4		9d. Date sign	and (Month, I	2006
			30. Name and address of person who of Sangem, Madh	ompteted cause of death (Item avi 32 Sou	n 23a) (Type.	Print) reene	Sheet,	Ba	Itimo	re 1	UMM	s, MD
No. of Lot	Sta Registr		31. Date file <b>b/</b> (Month, Day, Year)	32. Registrar's Signa	ature							

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer æ **Physician** 1:27 Ralph Edgar Brown March 16, 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Fecility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 213-16-8051 3/13/1923 83 Director Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examinations to be notified at 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 403 Beaglin Park Drive 21804 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Navy 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify. white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Director of Customer Service permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien important: if item 27 is marked other the eny injury or other traumatic event, the once. U.S. Postal Service 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edgar Francis Brown Lola Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma Brown/wife 403 Beaglin Park Dr., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 3/17/06 \* 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licensee <sup>2</sup>Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 alkenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS one well /Medical Due to (or as a consequence of) Examiner on weic PNEUMONIA ASPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 541915 To the Hospital or Attending Physician: The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. DEMENTIA Physician/Medical as attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient į 10 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 29c. License number Inle Noting March 16 15 2006 DO51359 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1415 . S. DIVISION ST SAUSBYRY MD 21804 NATESAN DR. USHA 32. Registrar's Signature State 0 2006 Men Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2006 11:20PM ELSTE LEIGH BIBLE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) GARRETT CO. HOSPITAL GARRETT OAKLAND 9. Birthplace (State or Foreign DAVIS, WV 5. Social Security Number 6. Sex 1□M 2 F 235-20-4327 Usual Residence of Decedent 10b. County TUCKER 10c. City, Town or Location DAVIS 10d. Inside City Limits 1 Xyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? RT. 32 PO BOX 154 26260 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (Z)No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BANK TELLER BANKING 17. Father's Name *(First, Middle, Last)*FREDOLPH BERGSTROM 18. Mother's Name *(First, Middle, Maiden Sumame)* THEKLA VICTORIA ANDERSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA VAN METER/NEICE 14115 OLD OLD TOWN RD., OLD TOWN RD, 20c. Location - City or Town, \$1.555 20a. Method of Disposition
1 △ Surial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
DAVIS CEMETERY 3-25-06 DAVIS, WV \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee THE THE CONTROL HOME, INC. PO BOX 186, DAVIS WV 26260 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ' Due to (or as a consequence or) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 → Noknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes 2/ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 🗘o 2 ER/Outpatient 27. Manper of Death 28d. Describe how injury occurred

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

or 28a-f show

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any lininy or other traumatic event page.

within 72 hours efter death

Baltimore, Maryland 21215-0036

Director

Funeral

Be Completed by

traumatic event, the Medical Examiner must be notified at

burial-transit

Completed by Physiclan/Medical

Be

Certification: To

Medical

Natural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

or Attanding Physician: The law requires that the death certificate be executed use as the

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funarel Diractor: After thi
completely filled in by the funeral To the Hospital

> State Registrar

29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

29c. License number D 23979

29d. Date signed (Month, Day, Year) 3216

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Robert Goralski, M.D., Garrett County Hospital

31. Date filed (Month, Day, Year) MAR 3 0 2006



# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			for State Registrar	State of Maryland		tificate of l			gleneo o o Reg. No.	10010
1	46		1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
	Physici /Medic		Florence J.	Catlett					14, 2006	10:20 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of E	Death
	4	, ·	Southern Maryland			Clinton				Georges
	Funeral		Social Security Number     6. Sex	IM SVETE		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		577-28-8076 Usual Residence of Decedent	82	Yrs.			Oct. 21	<b>,</b> 1923 Wa	shington, D.C.
	and will		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Varyl	ō	Maryland Prince G	George S	uitlan	ıd				1 Yes 2 □ No
	28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	3a or	<u> </u>	3110 Scottish Ave.			2074	5		United S	-
	death ms 2	Funeral		12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba		ecify Yes or No		American Indian,
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heelth and Mental Hygiene. If Item 27 is marked other then "natural", or Items 23a or 28a-f ehow or other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		_	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: B	White, etc.
Ö	2 hou	ed	15. Decedent's Educ	cation	16a. Deced	lent's Usual Occupa	ation		16b. Kind of Busine	ess/Industry
215	within 73 ene. then "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	furing most of work  )	ing		
212	d with	E O	12	College (1-401 5+)	Su	pervisor			Federal	Government
פ	tal Hygie d other event,	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Sumame)	
/lai	Aental Aental rked c	To E	Leon Jackson				Corinth	ia Crox	ton	
any	should and Men s marke tumatic	yr s	19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailin	g Address (Street a	and Number or Rur	al Route Numb	er, City or Town, Sta	te, Zip Code)
	and 2 selth n 27 i		Cheryl C. Wright/		A CONTRACTOR OF THE PARTY OF TH	Scottish		tland,	Md. 2074	6
ore	of He fiten		20a. Method of Disposition 1	20b. Pl	ace of Dispo	sition (Name of natory or other plac	θ)	Date	20c. Location - City	y or Town, State
Ē	Pag ment ent: I ury o		4 □ Donation 5 □ Other (Specify)			National		/2006	Laurel,	
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licens	ENAMOIUSS	22	Name and Address Alexande 5538 Mar	ss of Facility r.S. Pope Iboro Pik	Eunera e/Fores	1 Homes,	P.A. 20747
	F 9		23a. Part1. Enter the disease, or complishock, or heart failure. List only or							Approximate
1	Physician		Immediate Cause (Final	PITC, WALL	10	WiTH	58	C/C		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ	ence of):	Willia	30/ 4	<i>y</i>		DAY
н	Examiner		RESOURCE READING VINES UNIX							
		Jer	Sequer tially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	ence of):					
	tificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events							
oʻ	e exe ian al ırial-t	EX	resulting in death) Last	Due to (or as a consequ	ience of):					
68760,	ate b hysic he bu	edical								
		Med	IF FEMALE:			W.	2			
Вох	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregnancy			23d. Date of Month	f delivery Day Year
<u>.</u>	that the death cert ed by the ettendin detached for use	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant at time of de 9☐Unknown	eath 5□	Other (specify)			, work	ou, rou
P.O.	hat th od by detac		Part II. Other significant conditions con	stributing to death but not resu	liting in the ur	derhing cause and	on in Part I	23e Did t	ohacco use contribut	te to the cause of death?
ds,	8 6 6	l by	AUTE NEW	AC FAIL	ME	idonying dadab give	arrair dates.			Probably 4 Unknown
Ö	w require been si should l	etec	117/110/11/6/	AVIC CAON	OUA	COLLAD	NICA	~ -		
Division of Vital Records,	has l	Completed	HUMILOSCIAL	ALC CAPIT	CUM	CUCIPL	- ULANU	24a. Was autop	an 24b. Were psy prior primed? deat	e autopsy findings available r to completion of cause of th?
a								1 ☐ Yes		
ΖÏ	Physicien: this certific al director,	Be	25. Was case referred to medical examiner?	ارمین (معنی :lospital		Othe	26. Place of Deat	10		
of	Phys raidi raidi	- T	1 ☐ Yes 2 ♣ No	1 Inpatient 2 □ E	ER/Outpatien 28b. Time of	1 3 DOA	4   Nursing no		dence 6 Other (: how injury occurred	Specify)
O	ding Ainer After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injun Work	(? Yes 2 □No	200. 2000,100	non injury occurred	
S	or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	me, farm, stre			28f. Location (	Street and Number o	or Rural Route Number,
Ö	after after Dire	Certification:	4 Homicide	building, etc. (Specify,	)			City or To	wn, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai C	29a. Certifier (Check only one)	sicien: To the best of my knowner: On the basis of examinational and manner stated.	wledge, death ion and/or inv	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (M	fonth, Day, Year)
	0		10/1			17-1	8545		HARCH 1	4, 2006
0	(5)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)		4	00.0	. /
E			t, WISOVSKY de	(D. 12070	04	) UNE	COUTER	WHE	Hert, det	4, 2006 U. 20602
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 2006	32. Registrar's Signat	best	Ü				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

99		1 - For State Registrer	State of Maryland		artment of F		-	giene	4 U U b	10019
Physicia /Medic		1. Decedent's Name (First, Middle, Las $Vincent \ T.$	t) Chamberlain				2 Date of De Month March	ath Da	v Year	3. Time of Death 10:09 A M
Examin		4a. Facility Name (If not institution, give 2120 Weber Drive			Capitol	Location of Death Heights	h .	4c	County of Death	George's
Funeral Director		5. Social Security Number 214-08-4408 5. Social Residence of Decedent	7. Age (In yrs. last)	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		y, Year)		nplace (State or Foreign untry) nington, D.C
the Maryland 28a-f show	Director	10a. State 10b. County  Maryland Prince (	Georges For	own or Lo						10d. Inside City Limits  N Yes 2 No
s after deeth with the Maryla s, or iteme 23a or 28a-t ehov variant must be cotified at	eral Dire	10e. Street and Number 2120 Weber Dr.			10f. Zip Code 20747			Un	tizen of What Con	ates
filed within 72 hours after deeth with the Maryland Hygione. Hygione, wither then "naturel", or items 23s or 28s-f ehow ent, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√ No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	-	14. Race - Amer Black, White Specify: B1a	, etc.
within 72 hour ene. then "nature! he Madical Ex	Completed	15. Decedent's Ed (Specify only highest gra-		(Give life. l	dent's Usual Occup kind of work done o DO NOT use retired	during most of wor f)	rking		ind of Business/I	
permit. Peges 1 and 2 should be filed within the peges 1 and 2 should be filed within important: if item 27 is marked other then any injury or other treumatic event, it a Magnes.	To Be Co	17. Father's Name (First, Middle, Last)  Joshua Chamberla:	in	Ma	intenance	18. Morker Sara I				overnment
and 2 sho ealth and h a 27 is me		19a. Informant's Name/Relationship (7	ther 2	2120	ng Address (Street a	Foresty			or Town, State, Z 20747	ip Code)
t. Peges 1 trant of H trant: if ite		20a. Method of Disposition  1 ABurial 2 Cremation 3 4 Donation 5 Other (Specify	Resur	rect		3/20	Date 0/2006		nton, Mo	
Depariment Depariment Impo		21. Signature of Funeral Service Lines 23a. Part. Enter the disease, or comp	=52 M 01885	-	Name and Address Alexander 5538 Mar	S. Pope boro Pik	Funera ce/Fores	l Ho tvil	mes, P.	
Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	4	Would	Lot 14	evol .	rest,		Approximate Interval Between Onset and Death
executed on and rial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequent							
eath certific ettending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal de: 4 Pregnant at time of death	ath 3	Ectopic pregnancy Other (specify)		are.		23d. Date of delin	very Day Year
es ti	2	Part II. Other significant conditions or	ontributing to death but not resultin	g in the ur	nderlying cause give	en in Part I.	23e. Did to			the cause of death?
sicien: The law certificete hes b rector, page 2 si	e Completed	25. Was case referred to medical					12 Yes	rmed? 2 □ No	prior to co	opsy findings available ompletion of cause of
Attending Physicien: r death. sctor: Atter this certifica by the funeral director.	2 B	examiner?		Outpatien  5. Time of Injury	t 3 DOA Othe	4   Nursing H		lence		<sub>fy)</sub> at scene
of or Attend efter death Director: /	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)		M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	res 2 No	28f. Location (S City or Tow	Street and State	d Number or Rui	al Route Number,
he Hospi in 24 hou he Funer pletely fill	edical	one) 22 Mwaqicai Exam	vsicien: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death	occurred at the tim	e, date and place pinion, death occur	, and due to the orred at the time,	cause(s)	and manner as	stated.
Tot	Σ	29b. Signature and title of certifier	emo		29c. License	M.E.		Mar	te signed (Month, ch 14, 2	
(5)	1	30. Name and address of person who o	ompleted cause of death (Item 23	а) (Туре, <u>1</u>	l Penn St	reet, Ba	ltimore,	, Ma:	ryland	21201

State

31. Date filed (Month, Day, Year)
MAR 1 7 2006 Registrar DHMH 17 Rev 1/2001

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician TERRY CLARK 15, 2004 4c. County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 65 10/1/15 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign
Country) **Funeral** 1 XM 2 □ F None Yrs. Director MARCH 15 2006 BALTIMORE, MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show the Medical Examiner must be notified a 1 Yes 2 □ No Director PRINCE GEORGE'S OXON HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 MYSTIC AVENUE 20745 U.S.A. Funerai Peges 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced BLACK "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) NONE NONE 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be la marked o TIJUANA FLETCHER BERNARD CLARK JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TIJUANA FLETCHER/MOTHER 1600 MYSTIC AVENUE OXON HILL, MARYLAND item 27 l 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition o = 1 Burial 2 Cremation 3 Removal from State Depertment of Important: If any injury or once. RESURRECTION CEMETERY 3/20/06 CLINTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 24 hours ERVICA Incompetence disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his After this funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manger of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

within 2

29b. Signature and title of certifier

Ydward 31. Date filed (Month, Day, Year)

30. Name and address of person who completed

lanne

MAR 2 0 2006

se of death (Item 23a) (Type, Print)

2. Registrar's Signature

29c. License numbe

		1	For State Registrar	State of Maryland		artment of H rtificate of L			giene Reg. Wo.	6 1002	22
	o Lia		Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	3. Time of E	Death
ı	Physicia /Medic		Frances Elaine C	hiarizia				March		4 00 -	ì <sup>M</sup>
	Examin	4.00	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of E	Death	4c. County	of Death	
			119 A Street				othian			Arundel	Foreign
	Funeral	(P.55)	5. Social Security Number 6. Set	1 M 257 E	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, Da	y, Year)	Birthplace (State or Country)	Foreign
	Director	-	213-80-4578 Usual Residence of Decedent	46				1/16/19	960	MD	
	and w	I ⊩	10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City	y Limits
	Mary feh	tor	MD Anne Arun	de1		T,	othian			1 X Yes	2 🗌 No
	the r 28e	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?	
	3a o	Funeral Director	119 A Street			2	0711		U	SA	
	deati	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of Hi	ispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.	
9	after or Ita	Fu	1 ☐ Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☑ No	Specify:		Specify	/ white	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "neturel", or Iteme 23a or 28e-f ehow ent, the Madical Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	16a Dasa	dent's Usual Occup	ation		16h Kind of Bi	White usiness/Industry	
Ϋ́	"net	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired	during most o	f working	TOB. Halla of D	, and a management	
12	with:	шo	Elementary/Secondary (0-12)	College (1-4or 5+)		Waitress	5		]	Deli	
ק ק	Hiled Hyg other	Be C	17. Father's Name (First, Middle, Last)			7104 0 2 0 2 0		Name (First, Middle	, Maiden Suman	10)	
<u>a</u>	uld be fenta rked rked tic ev	To B	James Wesley More	1and				erine Lorr			
Maryland	should have	[ 9]	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street	and Number	or Rural Route Numb	er, City or Town,	State, Zip Code)	
Σ	and 2 paith n 27 i		John Chiarizia/Hus				Lothia	an, MD 207		City of Town State	
altimore,	of Ho		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	metery, cre	osition (Name of matory or other plac	1			City or Town, State	
Ë	Pagiment ment tent: jury o		4 □ Donation 5 □ Other (Specify)			on Nat'1 (		/16/2006	Suitla	nd, MD	_
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or Iteme 23a or 28e-f ehow amy injury or other treumatic event, the Madical Examiliar must be notified at ance.		21. Signature of Funeral Service Licens	600		2. Name and Addre		Raymond-W		., P.A.	
	403 e d		23a. Part1. Enter the disease, or comp	lications that caused the death				irk, MD 20		Approximate	0
	Physician /Medical Examiner		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequent	ater	Fac	lui	7		Interval Bett Onset and E	
	ad sit	iner	Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a c) nseq	ence of):	Cly.					
	cate be executed obysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consequ	ence of):						
8760,	e be e	cal		d							
9	ifficat g phy as th	ledical									-
O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 10 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	□Ectopic pregnancy □ Other (specify) _	y			ate of delivery onth Day h	Year
rds, P.	Se 50	þ	Part II. Other significant conditions co	ontributing to death but not resu	Iting in the	underlying cause giv	ren in Part I.		tobacco use con Yes 2 ☐ No	atribute to the cause of d	
I Records,	The law ate has b page 2 s	Completed						24a. Wa auto perf 1 🔲 Yes	s an 24b. opsy ormed? 2 No	Were autopsy findings prior to completion of c death? 1 \( \text{Yes} \) Yes \( 2 \text{\text{\text{No}}} \) No	available ause of
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hoopital:		0#	205	of Death Check only			
of	Physicie this cert al direct	2	1 Yes ZINO		ER/Outpation 28b. Time	ALL SEL DOA		sing Home 5 es	how injury occu		
u C		lon	27. Manna Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	Injury	Wo	rk? ]Yes 2 □ N		now injury cools		
Division	tent leath tor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		me, farm, s		,	28f. Location	(Street and Num own, State)	ber or Rural Route Num	ı <i>ber</i> ,
	Hospite 4 hours Funeral	edical Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my known inner: On the basis of examinat and manner stated.	wledge, dea ion and/or i	ith occurred at the ti nvestigation, in my o	me, date and opinion, death	place, and due to the cocurred at the time	e cause(s) and m , date and place	nanner as stated. , and due to the cause(s	s) _
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date sign	ed (Month, Day, Year)	
	۵≒٤≒		V C. 1.	A	111		) ( 33	06	3/1	3/06	
	6		30. Name and address of person who	completed cause of death (Item	23a) (Type	p, Print)	400	Annapo	die IM	1 21411	/
	St Regist	ate	31. Date filed (Mbnth, Day, Year)  MAR 1	32. Registra Signal	[5 4] ( ture	Sparks	<u>, 200</u>	NANCAGO		71/0	
100	1,09191	LECT.	I THIN	U LUUUP NEEDEN	a July	San Maria					

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e Carol	L Co	X 1 = For MFID#10e+19bpe Stan MFID#10e+19bpe Registran MFID#1apen	State of M FH3/15/06, BM F3/15/06, BM	aryland / Dep I,McCo Ce McCo Ce	artment of F ertificate of			giene Reg. No. 0 0	6 10023		
		Decedent's Name (First, Middle,					2. Date of Dea Month		3. Time of Death		
Physi /Med	ician dical	Sue Carol Cox					March 1		9.08 P M		
Exam		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County	of Death		
		8101 Schrider 8101 Schreiden	Street		Silver			Montg			
Funera Directo		226-50-4524	7. Ag 1 M 2 √F	ge (In yrs. last birthday 66 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day May 23,	1939	9. Birthplace (State or Foreign Country) Tennessee		
ehow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L					10d. Inside City Limits		
Mary Indian	tor	MD Montgor	nery	Silver S	pring				14 Yes 2 No		
h with the	Funeral Director	10e. Street and Number Schrider	Street #6		10f. Zip Code 20910			10g. Citizen of W USA	/hat Country?		
yiding X 1 X 1 2-0030 build be filed within 72 hours after death with the Maryland Mental Hygiene. acked other then "case or 28s-f ehow after event, the Medical Exemples mast be multified at	þ	11. Marital Status  xX Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces d 1  Yes 2 1 If Yes, Give Year or Dates:	?	Was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White		
72 ho	Completed	15. Decedent's (Specify only highest		16a. Deci (Giv	edent's Usual Occup e kind of work done DO NOT use retire	pation during most of work	king	16b. Kind of Bu	siness/Industry		
within then then	dwo	Elementary/Secondary (0-12)	College (1-4or 2	5+)	ice Worke			U.S. Gov	rernment		
e filed other	e C	17. Father's Name (First, Middle, La				18. Mother's Nam		Maiden Surnam	9)		
uld by Menta	10 E	John H. Cox				Flo Kilg	gore				
ind 2 sho alth and 1 27 ie me		19a. Informant's Name/Relationship (Type, Print)  John Cox  Father  19b. Mailing Address (Street and Wyng Ser or Rural Route Number, City or Town, State, P.O. Box 2265, Webber City, VA 24290									
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens important: If I tem 27 ie marked other then "nn eny injury or other treumatic event, I tem # and	3	20a. Method of Disposition  1 The Denation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Holston View Cemetery 03-17-2006 Weber City									
permit. Departminents Imports ony inju	OUCE	21. Signature of Foneral Service Li	e allayer		22. Name and Addres				Service, P.A. MD 20910		
		23a. Part1. Enter the disease, or c shock, or hear failure. List or	omplications that cause nly one cause on each I	d the death. Do not er ine.	nter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between		
Physicia		Immediate Cause (Final disease or condition	1		LARDIOVI		en		Onset and Death		
/Medica Examine		resulting in death)	Due to (or as	a consequence of):			9,50				
led nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequence of):	10)						
e executed e executed ien and urial-transit	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):							
cate be chysicii	edical		d			-5-					
The Could us, T.C. BOX 80100,  The law requires that the death certificate be executed are has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnanc □ Other (specify) _	у		23d. Date Mor	e of delivery ath Day Year		
quires that the den signed by the e	ĝ	Part II. Other significant condition	s contributing to death t	out not resulting in the	underlying cause giv	ven in Part I.		. /	ibute to the cause of death? 3 ☐ Probably 4 ☐Unknown		
ing Physician: The law require fing Physician: The law require Affer this certificete has been si uneral director, page 2 should t	Completed							sy p med? d	Vere autopsy findings available rior to completion of cause of eath2 ☐ Yes 2☐ No		
ian: rtifice rtor, p	0	25. Was case referred to medical			21-70	26. Place of Deal					
Physician: rthis certificant	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati	ent 2 ER/Outpatie	ent 3□ DOA Ott	200		lence 6 Othe	or (Specify)		
ing Pt	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time ay Year) Injury	of 28c. Inju	ry at	28d. Describe h	low injury occurre	bed		

Division of Vital Re-To the Hospital or Attending Phy within 24 hours after death.

7 To the Funeral Director: After this completely filled in by the funeral or 10

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 ☐ Pending investigation

6 Could not be determined

29c. License number

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

OCME

1 ☐ Yes 2 ☐ No

March 11, 2006

MARGAGUM 10000

111 Penn Street Baltimore, Maryland 21201

State Registrar

Medical Certification

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 🗌 Homicide

31. Date filed (Month, Day, Year)
MAR 15 2006

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year March 17, 2006 5:47 a.m. Chase John Duron 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Days Min 1 XM 2 ☐ F Months Hours Maryland 58 213**-**46**-**5159 Jan. 8, 1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No St. Mary's Maryland Hollywood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23837 Tin Top Hill Lane 20636 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 📉 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Taxi Cab Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James William Chase, Sr. Florence Anita Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> James W. Chase / Father</u> 23837 Tin Top Hill Lane, Hollywood, NO 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem 3-23-2006 Charlotte Hall, MD 21. Signature To neral Service Cense Edward N. Brinslield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) tic Cardiovarior selo Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) 23d. Date of delivery

Physician /Medical **Examiner** 

certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

death.

Hospital or within 24 hours e To the Funerel L

efter death Director: filled in by the Examine

Physician/Medical

۾

Completed

Be

Certification: To

Medical

**Physician** 

/Medical

Examiner

Directo

Funeral

þ

Completed

**Funeral** 

Director

other than "natural", or iteme 23s or 28s-f show vent, the Modical Examiner must be notified at

hours after

2 should be f and Mental I is marked

permit. Pages 1 and 2 sh Department of Health and Importent; If Item 27 Is m eny injury or other traum

Maryland 21215-0036

Baltimore,

burial-transit ettending physician for use as the buria ed by the detached signed t cete has been sig , page 2 should b certificete has funeral director this After

IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

Month 23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

1 Yes 2 No 3 Probably 4 Nnknown 24a. Was an autopsy performed 2 No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Day

25. Was case referred to medical examiner? 1 Yes 2 No Manner of Death 1 Natural 2 Accident

29b. Signature and title of certifier

9 🗌 Unknown

1 Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 28b. Time of Injury 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Yes

26. Place of Death (Check only one)

29a. Certifier (Check only one)

3 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 14285

29d. Date signed (Month, Day, Year)

-2306

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

WY

William D. ΙÌ, Boyd M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Pay 2

State Registrar

32 legistrar's Signature 4 2006



		-	For State Ragistrar		State o	of Marylan		artmen <i>rtificati</i>			nd Me	ental Hy	gieņe Rag. No	Hillia	10025	
-3.	- Pagenta	集	1. Decedent's Name (	First, Middle, Las	st)						2	2. Date of De Month	eath Day	y Year	3. Time of Death	
	Physicia /Medic		Robert	Lec		Cleer						larch	16,	2006	1770	М
	Examin	er	4a. Facility Name (If no			mber)				Location of	f Death			County of Dea St. Mar		
<i>\$</i>			St. Mary 5. Social Security Num			7. Age (In yrs.	last birthday)	If Under	1 Year	dtown If Under 2	4 Hrs.	B. Date of Bi	rth.	Q Bir	tholace (State or Forei	gn
	Funeral Director	1	234-12-939	- 1	<b>∑</b> M 2□F	85	Yrs.	Months	Days	Hours	Min.	NOV .	av Year	.920 Wes	t Virginia	
	D		Usual Residence of D			10. 0	. Town and								10d. Inside City Limit	
	anylar show	5		Ob. County  Charle:	^		y,TownorLo La Pla								1 (X) Yes 2 □ N	
	28s-1	ecto	Maryland  10e. Street and Numb		>		La Fia	10f. Zip	Code				10a. Cit	izen of What C	ountry?	
	Mith 3a or	Di	1003 Wale						0646					S.A.	•	
	death	nera	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Deced	dent of His	spanic Orig	gin? (Spec	ify Yes or Nican, etc.)	0-	14. Race - Ame Black, Whi		
336	72 hours after death with the Maryland "natural", or Itema 23a or 28a-1 ahow cilcal Examinar must be notified at	by Funeral Director	1 ☐ Never Married 3 🛣 Widowed 4			2 No 194	+2-	1 ☐ Yes		Specify:	, 1 00110 11			Specify: Wh		
21215-0036	72 hor	e Completed		5. Decedent's Ed		)	16a. Dece	dent's Usua kind of wo	al Occupa	tion uring most	of working	2	16b. K	ind of Business	/Industry	
21	within ene. than "	nple.	Elementary/Second			1-4or 5+)		oo Notu ceman					Da	il Road		
	Hygier Ther th	S	17. Father's Name (Fi	rst. Middle. Lasti	1		1011	Ceman	-	18. Mother	r's Name	First, Middle				
Maryland	d be f	To Be	Charles							Anna	Vict	coria	Clee	r		
ary	shoul nd Me mark	F			Type, Print) F	ıneral	19b. Maili	ng Address	(Street a	nd Number	r or Rural	Route Numi	ber, City	or Town, State,	Zip Code) 22801	
	alth a alth a 127 is		19a. Informant's Nam Lindsey Fu	uneral H	ome/Di	rector	473	South	Mair	n Stre		- XXX15A	+	urg, Vi		
ore	of He fiterr		20a. Method of Dispos		Removal from		Place of Disposemetery, cre	osition (Nai matory or c	me of other place	a)	March 2006	19.	0	ocation - City or		
Baltimore,	Pag tment tant:		4 Donation 5	Other (Specif	<b>'y</b> )	Woo	dbine								rg, Virgin	- A
Ball	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than any july or other traumetic event. If a Magnet.		21. Signatore of Fune	oral Service Licer	Paul	0053 >				s of Facility					on Road 20604-015	6
			23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that one cause on	caused the deat each line.	h. Do not en	ter the mod	de of dying	g, such as o	cardiac or	respiratory	arrest,		Approximate Interval Between Onset and Death	
	Pnysician	(5 )	Immediate Cause (Fi disease or condition resulting in death)	nai	a	54	1001	-							170411	
	/Medical Examiner		resulting in death)	ſ	Due to	(or as a conseq	uence of):	,20	nal	fer	,100	2			13471	
		er	Sequentially list cond if any, leading to imm	litions, rediate	b. Due to	(or as a conseq	uence of):  n   c  uence of):  for to		.,							
	d d ansit	Examine	cause. Enter Underly Cause (Disease or in that initiated events	/ina	C	1019	boste	. 1 7	ne II	itus	7	170	2_		1747 1	
ó	be executed ician and burial-transit	Ехв	resulting in death) La	st	Due to	(or as a conseq	uence of):								17975	
8760,	cate be execu physician and the burial-trai	dicai			d	714	oun	aron n							/-	
9		/Mec	IF FEMALE:		23c If yes o	utcome of pregna	ancy							23d. Date of de	Ninor.	
Вох	The taw requires that the death certificate has been signed by the attending to age 2 should be detached for use as	by Physician/Me	23b. Was decedent p in the past 12 m	onths?	1 Live	birth 2 Feta	death 3	☐Ectopic p ☐ Other (sa						Month Month	Day Year	
P.O.	by the a	ysi	1 ☐ Yes 2 ☐ I 9 ☐ Unknown	No	9□ Unkr				,,							
	es that igned b	y Pi	Part II. Other signific			death but not res	ulting in the u	inderlying o	cause give	en in Part I.		23e. Did	tobacco	use contribute	to the cause of death?	
rds	w require been sig should b			emeni	1~							1 🗆	Yes 2	!□No 3□F	robably 4 Unkno	wn
eco	e taw requ has been je 2 shouk	Completed	- Be	ningr	- Pars	stall c	בקדא	in the	アカン			24a. Wa aut	opsy	prior to	utopsy findings availal completion of cause of	ole of
<u>=</u>		Соп										1 Yes	formed?	death? 1 ☐ Ye	s 2 No	
Vita	icien: T certifical rector, p	Be	25. Was case referre examiner?		Hospital:	/			Othe	00		(Check only				_
of	this al dii	. To	1 Yes 2 N	0	28a. Date	of Injury	ER/Outpatie		28c. Injury Work	4 🗀 1901		e 5 ☐ Re: 8d. Describe		6 ☐Other (Sp.	ecify)	
lon	th: :: After s funer	tion	1 Natural 2 Accident	5 Pending investigation		nth, Day Year)	Injury	М		k? Yes 2 □ f	No					
Division of Vital Records,	Atter ector by the	tifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	280. Plac	e of Injury - At h	ome, farm, si	reet, factor	y, office		2		(Street a		Rural Route Number,	
Ō	rs after or rs after is in Dir	Cert													<u> </u>	
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical Certification:		Certifying Pl	miner: On the										as stated. ue to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and ti					29	c. License	number				ate signed (Mor		
	. /		) DÍ	Thav					D006	1719			3	. 16 . 06		
-	Ale I		30. Name and address						0	11 7	7.	٠	_	- 1 000	.00	
14	18,		Dhanajay	Bnavsa Day Year	r, MU,	24035 T	nree N	otch	Koad	, HOI	Lywo	oa, Ma	ıryla	ma, 206	30	
	Sta Regist	ite rar	31. Date filed (Month	MAR 1	7 2006	Register's Sign	15									

Robert

Cleck,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** March 15, 2006 10:05 A Dravo Susan Lynn /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🙀 F Yrs. 54 7-21-1951 Washington, DC Director 216-58-6436 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County in than "natural", or Itams 23s or 28s-1 show the Medical Exeminer must be notified at 1 ☐ Yes 2 XNo Directo Anne Arundel Maryland Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 USA 417 Epping Way death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural; or Itam any Injury or other traumatic event, the Medical Exemples 9DCs. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ☐ Widowed 4 ₹ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be Clifford Edward Axel Johnson Margaret Claire McIntosh 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 451 Honereng Trail, Annapolis, MD 21401
of Disposition (Name of Date 20c. Location - City or Town, State Darren M. Johnson/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3-16-06 Kalas Crematory Edgewater, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Ulu 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Ortset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Brainstem hemorrhage Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and tor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) been signed by the s should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> 1 Yes 2 No 3 Probably 4 KUnknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certiticate has t irector, page 2 s 2 0 No 1 Yes To the Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this Atter thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident atter death 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a

To the Funaral C 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46052 30. Name and address of person who completed cause of death (Hemiza) (Type, Print) Pourkway amapolo, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 6 2006 Registrar

		1- For State of Maryland / Dep	ertment of Health and Mertificate of Death	177	ene g. No. 0 0 6	10027
		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physic /Medi		ROBERT MELVIN DURBIN, SR		Month MARCH	16 2006	1:04 P M
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		HARFORD MEMORIAL HOSPITAL	HAVRE DE GR. If Under 1 Year If Under 24 Hrs.		HARFO	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 2 F 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, ) March 6,		lace (State or Foreign stry)
_		Usual Residence of Decedent		march o,		yland
nylan show	_	10a. State 10b. County 10c. City, Town or L			1	0d. Inside City Limits 1 XYes 2 No
Ba-1	Director	Maryland Harford	Havre de Grace			
ite, with yield KIKIS-00000  I and 2 should be filed within 72 hours after death with the Maryland fileelth and Mental Hygene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercited must be notified at		10e. Street and Number 230 Superior Street	10f. Zip Code 21078	100	g. Citizen of What Cour USA	itry :
Jeath me 23	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
after o	F	1 Never Married 2 Married   Armed Forces?  1 Never Married 2 Married   1 Never Marri		Rican, etc.)	Black, White,	
iral;	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1955–57	1 ☐ Yes 2 X No Specify:		Specify: B	.ack 
natu	Completed	(Specify only highest grade completed) (Giv	edent's Usual Docupation e <i>kind of work done during most of work</i> DO NOT use retired)	ting	6b. Kind of Business/Ind	dustry
withir lene.	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	Cement Finisher		Construc	tion
Hygier (	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		01011
in yiania 212. should be filed within nd Mental Hygiene. marked other then imatic event, the Ma	To B	William A. Durbin, Sr.	Annie 1	M. Croxse	ell	
2 should and Menis market			ling Address (Street and Number or Run		-	
and and man			Warwick Drive, Ap			
Pages 1 ar		1 🖫 Burial 2 Cremation 3 Removal from State	ematory`or other place)		0c. Location - City or To	
			n Forest Vet. 3/2' 22. Name and Address of Facility	7/06 <u>C</u>	Wings Mill:	s, Maryland
permit. Departrimports ony inju		P. Sott	Lisa Scott Fune 552 Lewis Stree	eral Home	P.A.	MD 21078
-		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ancer I a	note o	toon	Onset and Death
/Medical		resulting in death)  a  Due to (or as a x nseque, ce of):	2000	The Contract	year	
Examiner	L	Sequentiany list conductors,	Molloties			
ed Islt	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	hataition			
xecut and	Examine	that initiated events c. Due to (or as a consequence of):	say across	1	- 1	
cate be executed physician and the burial-transit	dicai E	2 Dehn daras	lyon, Ken	al f	arlun	2
tificate g phy as the						777
th cer tendin	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐Ectopic pregnancy		23d. Date of delive	
e deal	sicia	in the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5	Other (specify)		Month	Day Year
hat the		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did toba	acco use contribute to the	ne cause of death?
The Coulds, T.O. BOX Of The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as:	d by	The state of the s	and any my seed as given any care in	1 🗆 Yes		ably 4 Unknown
y requ	Completed			24a. Was an	24b. Were auto	psy findings available
he la e has	d HC		····	autopsy perform	ed? death?	psy findings available mpletion of cause of
an: T ufficat tor, pa	0	25. Was case referred to medical	26. Place of Deat	1 ☐ Yes 21 th Check only one	No 1 Yes	2 U No
nysici nis cer direc	To B	examiner?  1 Yes 2 No Hospital: Inpatient 2 ER/Outpatie	Other		nce 6 Other (Specif	y)
ng Pt C		27 Manuar of Death 28a. Date of Injury 28b. Time (Month, Day Year) Injury Injury		28d. Describe how	w injury occurred	
tor: A	cati	2 Accident investigation	M 1 Yes 2 No	201 1		
or All after of Direct	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	City or Town,	eet and Number or Aura State)	ii Houte Number,
spital lours neral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the cau	use(s) and manner as s	tated.
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, dat	te and place, and due to	the cause(s)
To the transfer of the transfer of the transfer of tra	Σ	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Daly, Year)
		The M.V.	12000		2/16/0	06
3+1VA		30. Name and adverse of person who completed cause of drain from 23() (Type	o, Print)	Arur	x do t	rass
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	much	01001	1110	7/00
	rar	MAR 2 0 2006 Blown II Aparle			1000	000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician Emilie K. march 12,2000 Esayian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ar guredels race Citizens lome If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** 1 □ M 2 🛛 F Yrs. 12/24/1912 Turkey 160-10-5970 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State works ref', or items 23e or 28e-f shov Examiner r-ust be natified at 1 Yes 2 □ No Harford Havre de Grace Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21078 415 S. Market Street Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 XWidowed 4 □ Divorced "neturef" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry er than "netur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumbing Elementary/Secondary (0-12) College (1-4or 5+) Comtometer Operator 12 18. Mother's Name (First, Middle, Maiden Sumame) marked other 17. Father's Name (First, Middle, Last) Be Natouhie Kazaniian and Mental Setrag Kasparian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 60 Boothby Dr., Mt. Laurel, NJ 08054 Joyce Hare Daughter item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it eny injury or o ō 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bala Cynwyd, PA 03/15/06 West Laurel Hill Cem. A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Strano & Feeley Family Funeral Home dutie 635 Churchmans Rd., Newark, DE 19702 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, oxcomplications that caused the death. Do not enter 1,4 mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Burlen Physician /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 pronths? 1 ☐ Yes 2 DNo 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ of Vital Records, 1 Yes 2 No 3 Probably 4 nknown page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes the funeral director. 26. Place of Death (Check onl. one Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 3□ DOA Certification; To 28d. Describe how injury occurred 27. Manner of Death the Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day) 29b. Signature and title of fiftier completed cause of death (Item 23a) (Type 32. Registrar's Sign State Registrar

saylary, Emille

Lin	01941 da R. E	lng.		<b>Please</b> cen# 23a, 27	Type or , 28a-1, State o	Print ir pende of Maryla					<b>All Cop</b> Mental	ies Are Hygien	Legi	ble.	10029
RJD			1 - State Registrar				Ce	rtifica	te of l	Death		Reg. N	lo.		
	Physici			ne (First, Middle, Las .nda Rose		2					2. Date of Month	ch 19	ay 200	) 6 <sup>ear</sup>	3. Time of Death OO34 A. M
P	/Medic Examir		4a. Facility Name (	If not institution, give ter Genera	street and nu	ımber)		4b. City	y, Town, or ibrids	Location of Deal		4	c. County	of Death	
2	Funeral	11 M 2MF													place (State or Foreign
5	Director		215-72-2 Usual Residence o	969		4	2 Yrs.						1963		yland
5	death with the Maryland time 23s or 28s-f show	ō	10a. State	10b. County  Dorche	ster	10c.	City, Town or Le		lambr:	idae				1	0d. Inside City Limits 1 XYes 2 □ No
$\aleph$	or 288-	Director	10e. Street and Nu						ip Code			10g. C	Citizen of V	What Cour	ntry?
$\zeta_{j}$	th wi	al	304 E	ast Apple	by Ave.	•			2	21613			USA		
980	urs after ai', or ite	by Funeral	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried 2 🛣 Married 4 □ Divorced	12. Was Dec Armed For 1 Tes If Yes, Gi Year or D	orces? 2⊠No ive			edent of H ecify Cuba 2 XNo	ispanic Origin? (S n, Mexican, Puer Specify:	Specify Yes to Rican, etc	or No-		k, White,	an Indian, etc. ite
5-0	72 ho	eted	(Spec	15. Decedent's Ed cify only highest grad	ucation de completed)		16a. Dece	kind of w	vork done d	during most of wo	nking	16b.	Kind of Bu	ısiness/In	dustry
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<u>/a</u>	Venta	2	Danie	l James L	awler					Dor	is Pay	ne			
lan	and I	1 2	19a. Informant's N	ame/Relationship (7	ype, Print)		19b. Maili	ng Addre	ss (Street	and Number or R	ural Route N	umber, City	or Town,	State, Zip	Code)
Σ.	and Seelth		Doris	Parks	moth					Ave., C	ambrid	ge, M	D 21	613	
Baltimore,	ages 1 nt of H t: if ite: / or oth			☐Cremation 3 ☐		State	b. Place of Dispo cemetery, cre	matory or	other plac	· 1	Date		Location -		
臣	artme prtan injury		1	5 ☐ Other (Specify ineral Service Ucen:		1	Cambrid			s of Facility T	23/06		mbrid		
Ba	Depa Impo any i		$\mathcal{L}$	4 I Ver						St., C				613	•A•
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68760,	eath certificate be exe attending physicien a for use as the burial-i	-	resulting in death)	Last	Due to	(or as a con	sequence of):								
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	ires thet signed b I be deta		Part II. Other signi	ficant conditions co	ntributing to d	leath but not	resulting in the u	inderlying	cause give	en in Part I.	23e.	Did tobacco			ne cause of death?
COL	sw requires s been si 2 should l	Completed										Was an	24b. \	Nere auto	psy findings available
al Re	ding Physician: The lav h. After this certificete hes funeral director, page 2:											autopsy performed? 'es 2 🗆 N		prior to co death?	npletion of cause of 2 No
Vit.	ician: Th certificete rector, pag	Be	25. Was case refer examiner?		Hospital:				1.0%	26. Place of De	ath (Check o	only one)			
ot	Phys this al dir	2	1 Yes 2 2	INO	1 1 1		ER/Outpatie	_		4   Nursing i					v)
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Division of Vital Records,	To the Hoepital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 4 Homicide	6 📉 Could not be determined		e of Injury - A ing, etc. <i>(Sp.</i> <b>.ind</b> at h	At home, farm, st ecify) NOME	reet, facto	ory, office		28f. Locat City of	r Town, Sta	<sup>te)</sup> 304		opleby Ave.
	To the Hoepital or within 24 hours afte To the Funeral Directional Completely filled in It	edical	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	iner: On the b	e best of my pasis of examiner stated.	knowledge, deal nination and/or in	n occurre vestigatio	d at the tim on, in my op	e, date and plac pinion, death occ	e, and due to	the cause	s) and ma	nner as s	ated. the cause(s)
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			Jois	4	6	mo			O.C.M	.E.		Marc	h 19	, 200	06
				ess of person who co		se of death (	Item 23a) (Type,	Print) 1:	11 Pe	nn Stree	et, Bai	Ltimor	re Ma	rylar	nd 21201
	Sta Registi	_	31. Date filed (Mon	nth, Day, Year)	2 2006	Registral's Si	gnature	Au	and L						

			1 - For State Registrar	State of Mary	land / Depa	artment of F	lealth and	Mental Hygi	ene006	10030
	° Physici	an	1. Decedent's Name (First, Middle, Las	st)			•	2. Date of Death Month	Day Year	3. Time of Death
	/Media	al	Leroy F  4a. Facility Name (If not institution, give	isher, Sr		4h City Town o	r Location of Dea	03	4c. County of Dea	
	Examir	ier	Crescent Cities C			Hyattsv			Prince Geo	
4,	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Birth	Year) 9. Bir	thplace (State or Foreign buntry) NC Derland Co.
	Director		246-24-2426 Usual Residence of Decedent	XIM 2□F 92	Yrs.	,		6/13/19	13' Cumb	erland Co."
	/land		10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. Inside City Limits
	Man e-1 sh	ctor	MD Prince G	eorge's	Hyattsvi	.11e				1 Yes 2 No
	ith the	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?
	s 23e	rai	4409 East West H		5-110	2073		2	United St	
	ter de	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces?			an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
936	al', or	by	3 Widowed 4 □ Divorced	1 ☐ Yes 21 No If Yes, Give Year or Dates:		1□ Yes 2 No	Specify:		Specify:	Black
5	72 hc 'netui	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occup	during most of we	orking 1	6b. Kind of Business	/Industry
7	within ane. than	mp	Elementary/Secondary (0-12)	College (1-4or 5+)	,	enance V	d) Worker		Private	
2 2	filed Hygi other ent,	Be Co	6 17. Father's Name (First, Middle, Last)					me (First, Middle, M		
<u>lan</u>	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "netural", or Items 23s or 28e-1 show marked other than "netural", or Items 23s or 28e-1 show marke event, it a Medical Examiner man be multipled at	To B	Unknown				Unknow	n		
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<u>ح</u> نه	1 and Health sm 27 sher tr		Leroy Fisher, Jr. 20a. Method of Disposition			S-street		shington,	DC 20001  Oc. Location - City or	Town State
Jor	Pages nent of H snt: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐	Inellioval floid State		osition (Name of matory or other pla	2/	18/2006 Fa		
altimore,	artme orteni injury	1	<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funerell Service Licen</li> </ul>		Cross Cr	eek Cemet		ort Lincol		
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Vital	sicier certif	o Be	25. Was case referred to medi   1 examiner?	Hospital:	2 ER/Outpatier	nt 3 DOA Oth	an at	eath <i>(Check only one</i> Home 5 \to Resider		nife!
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	ne Hosp n 24 hou ne Funei	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my niner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at the tir vestigation, in my o	me, date and place pinion, death occ	e, and due to the cau surred at the time, dat	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	NIA		29c. Licens			d. Date signed (Mont	
			1 UX No	_170		0	4831	3	03-15-	2006
2	(2)		30. Name and address of person who	completed cause of death	(Item 23a) (Type, 441)		Ave	landa	restalls.	2006 4D20784
Ž.	Sta Registr		31. Date filed (Month, Day, Year)	Registrar's S	Signature.	À,				

			For State Registrar	State of	Marylan	-	artment of H tificate of L		d Menta	l Hygiei Reg.	2000	10031
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)						Mo		Day Yeer	
	/Medic	al	Ann Giannetta  4a. Facility Name (If not institution, give	troot and numb	er)		4b. City, Town, or	Location of D	Mar		9 2006 4c. County of De	3:45 P M
	Examin	er	Crofton Convalesc				Crof		70401		Anne Ari	
	Funeral		5. Social Security Number 6. Sex	7.	Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date	e of Birth nth, Day, Ye		irthplace (State or Foreign Country)
	Director		129-09-0503	M 2₫F	88	Yrs.	Months Days	Tiodis is	Feb.		918 All	entown, PA
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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	be filed within 72 hours after death with the Maryland Hygiane. Id other then "neturel", or items 23a or 28e-f show to other then "neturel", or items 23a or 28e-f show event, the Madical Examiner must be incitited at	ral	1643 Eton Way					114			USA	
	ltems	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	<ol> <li>Was Deceded</li> <li>Armed Force</li> <li>1 ☐ Yes 2</li> </ol>	es?	S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origin' n, Mexican, P	? (Specify Ye uerto Rican, e	s or No- etc.)	14. Race - An Black, Wh	
0000	urs af	by	3 ∑Widowed 4 □ Divorced	If Yes, Give Year or Date	22		1 ☐ Yes 2 ☑ No	Specify:			Specify: W	hite
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=			Maria C. Farr/ Da	<i>i</i> ghter	1		3 Eton Way	y Croft				
ore	Pages 1 nent of H ont: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from St	ate C	emetery, crer	sition (Name of natory or other place	'	Date		. Location - City o	
aitimor		1	*4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licer  \$ 1. Signature of Funeral Service Licer  \$ 2. Signature of Funeral Service Licer  \$ 3. Signature of Funeral Service Licer  \$	88	Met		itan Crem . Name and Addres	, -			lexandri	a, VA
n n	permit. Departr Import any inju		* Juanara X	. Bu	Wton		512 NW Cr			runer wie, M	al Home D 20715	
П			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that cau	sed the death	n. Do not ent	er the mode of dying	g, such as car				Approximate Interval Between
,	Physician <sup>*</sup>		Immediate Cause (Final disease or condition			otic Ce	erebrovaso	cular I	Disease	2		Onset and Death  month
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	ovascula					years
b		er	Sequentially list conditions, if any, leading to immediate	o	as a conseq			101500	100			years
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ď,	e exec ian an urial-tr		resulting in death) Last	Due to (or	as a conseq	uence of):						
0 / p	certificate be executed adding physician and use as the burial-transit	dlcal		d								
٥ ×	ding se a	a)	IF FEMALE:	3c. If yes, outco	me of pregna	incy					23d. Date of d	lelivery
go.	atter for u	Iclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No	4 Pregnar	h 2□Feta nt at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
5	the ache	Physi	9 🗌 Unknown	9∐ Unknow	m							
	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions con	ntributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.	23			to the cause of death?  Probably 4 □Unknown
Hecords		Completed								. 27	1	
Ž Ž	sicien: The law certificate has b irector, page 2 sl	ldmo								<ul> <li>a. Was an autopsy performed</li> </ul>	prior to death	
VITAL	en: Th	e Co	25. Was case referred to medical					26 Place of	Death (Chec	Yes 2X	No 1 Y	es 2 No
	<u>&gt;</u> . <u>∞</u> 0	To B	examiner? 1 ☐ Yes 2 ☑ No	fospital: 1 ☐ Ing	patient 2	ER/Outpatier	nt 3 DOA Othe				e 6 □Other (S <sub>I</sub>	pecify)
o uc	Jing After fune		27. Manner of Death  1 ☒ Natural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	Work	vat ⟨? Yes 2 ∐ No		escribe how i	njury occurred	
DIVISION	Attending or death. ector: After by the fune	fical	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place o	f Injury - At h	ome, farm, sti	eet, factory, office		28f. Lo			Rural Route Number,
S	rs after al Dire	Certification:	4  Homicide Getermined	building	, etc. (Specif	y)			Cit	y or Town, S	rare)	
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the b ner: On the bas and manne	is of examina	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	ne, date and pointion, death	place, and due occurred at th	e to the caus ne time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		11-	700	29c. License		100	29d.	Date signed (Mo	nth, Day, Year)
			* Karkes	10	101	191	(I) V	20	100		5/20/	06
_	(3)		30. Name and address of person who co					a	205 5	los el	MD 225	1 -
	Sta	te	Rakesh Arora, M. [ 31. Date filed (Month, Day, Year)	a. Re	gistrar's Signa	iture	ox Lane	Suite	222 E	owie,	MD. 207	15
	Registi		MAR 2 0 2006	Ken	w 16	don	181					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 9:30 P<sup>M</sup> Phyllis Rutter Gorden March 14, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick

| H Under 1 Year | H Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | Dec. 15, 1931 Homewood Nursing Home Frederick 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🐼 F 74 370-32-6683 Yrs. Pennsylvania Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f ahow Tre Madical Examiner must be notified at 1 ☐Yes 2 ☐ No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1508 Cedarcrest Lane 21702 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If itam 27 is marked other 11 any injury or other traumatic avent, III. 2008. 4 News Dealer Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Rutter Adelaide Warfel ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ardine Gorden / Husband 1508 Cedarcrest Ln., Frederick, MD 21702 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition March 17, Resthaven Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Frederick, Maryland Gardens 21. Signatura 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1 Ther the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure 1 ist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 3-4 Days preumenie /Medical Due to (or s a consequence of) Examiner Sequentially list conditions, I any, learning to mine attacture. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 No the Hospital or Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) After th 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the crosse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only onel 29b. Signature and tall of certifier 29c. License number Shah Hison mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

hanson

Thomas

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31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 8:34P M Ella GASPAR March 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√□ F 86 Yrs. Romania Director 059-26-3571 July 23, 1919 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Itam 27 is marked other then "natural", or Itama 23a or 28a-1 show any injury or other traumatic event, the Marical Experiment rough an once. 28a-f show 1 ☐ Yes 2 No MD Montgomery Potomac Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10713 Goldwood Ct. 20854 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed by 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 College (1-4or 5+) Elementary/Secondary (0-12) Artist Painting Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moshe Feig Sarah Heimovich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maurice Gaspar, Son 10713 Goldwood Ct., Potomac, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Beth Israel Cemetery | March 17, 2006 Woodbridge, NJ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home
254 Carroll St., NW Washington, 21. Signature of Funeral Service Licens 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-transit Due to (or as a consequence of):  $\bigcirc$  []  $\bigcirc$  [  $\bigcirc$   $\bigcirc$   $\bigcirc$   $\bigcirc$   $\bigcirc$  Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) cete has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificete has 1 Yes ₹₹No Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Dther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 XNatural 5 Pending nours after death.
neral Director; After filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mio D055480 March 16, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brendan J. Carmody M.D. 8600 Old Georgetown Rd. Bethesda, MD 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) 2008 13131 Registrar

John Watter GEI Department of Health and Montal Hygiene.
Important: If itam 27 is marked other then "nate eny injury or other traumatic even"

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) March 5:00 PM 14, 2006 John Walter Gepert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Lanham Doctor's Community Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number Year) 1**X** M 2□F 80 10/09/1925 Pennsylvania 578-28-1829 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Prince George's Maryland Seabrook 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20706 USA 9507 Sheridan Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Coltege (1-4or5+) Elementary/Secondary (0-12) Drug-Retail Chief Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Helen Krujesky Edward Gepert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9507 Sheridan Street Seabrook, MD 20706 Eva Gepert/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition WBurial 2 ☐ Cremation 3 ☐ Removal from State George Washington 4 ☐ Donation 5 ☐ Other (Specify) 03/17/2006 Adelphi, MD Cemetery
22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee Jelm 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 m ANTERIOSCUSRATIC Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner requires that the death certificate be executed

Examiner

Physician/Medical

ģ

Completed

Be

Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28e-f show

or Items 23a

Direct

Completed

other traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-tran is been signed by the should be detach. page 2 After the funeral death. within 24 hours after death To the Funerel Director: completely filled in by the

Division of Vital Records, P.O. Box 68760

or Attending Physician:

25. Was case referred to medical examiner?			
	25.	referred	to medical

26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how intury occurred

27. Manner of Death	
1.⊠Naturat	5
2 Accident	
3 Suicide	6
4 ☐ Homicide	

investigation Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier	1X Certifying Phy
(Check only	2 Medical Exam

☐ Pending

ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b.	Signature	and	title	of certifier

29c. License number DG05821 29d. Date signed (Month, Day, Year) 3-15-06

phyllo 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Kennelworth Ave Suite2400 Riverdale Md 20131 Roger Inglam MD 6510
31. Date filed (Modith, Day, Year) 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 11 11 15 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 03 Year 06 **Physician** 11:35 P M 16 Wallace Linton Hodges /Medical 4c. County of Death 4b City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Fort Washington Fort Washington Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Dey, 12 10 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1⊠M 2□F 72 Yrs NC Director 239-46-3519 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ans: if Item 27 is marked other than "naturat", or iteme 23a or 28a-f show the transfice event, Ite Medical Examinat mail to notified a try or other traumatic event, Ite Medical Examinat mail to notified a 1X Yes 2 No Fort Washington Director MD Prince Georges 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3342 Huntley Square Drive, Apt. T-2 20748 United States Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after a I Hygiene. other than "naturat", or ites 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 1953-61 Specify: Black δ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Supply Technician Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Christine Headen Loomis Hodges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type Print) Marcia Dial-Kimbrough/Daughter 7200 Jaywick Avenue, #212, Ft. Washington, MD 20744 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If eny injury or \* 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cem. 03-24-06 Cheltenham, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licensee 6500 Allentown Road, Camp Springs, MD 20748 NIC 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) day **Physician** 0 Due to (or as a consequence of): /Medical **Examiner** Q Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed physician and s the burial-transit Jam C Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 102 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate ha 2□ No 2 No 1 ☐ Yes 1 ☐ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (Inpatient 2 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending 1 Matural 1 Yes 2 No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical within 24 h (Check only one) and manner stated 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 44046 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) caplata Md. 20646 Centinneal St. A. M. Alikhani 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 0 2006

DHMH 17 Rev 1/2001

Registrar

	nda P. 0 <b>1</b> 949	На	11 Please Unpend item#23a,PII,2	Type or Pri	nt in Black	<u>k</u> Inde	lible Ir	ık. Ens	ure A	II Copies	Are L	.egible.			
crn			1- State Registrar	, <b>\$35</b> , 5/24/	ary (and or d	epartr <i>Certifi</i>	ment o	f Health of Deatl	and N		giene Reg. No.	006	( )	036	
1	Physic	ian	Decedent's Name (First, Middle, Last		isia Dalla		- 11			2. Date of Dea Month		- Year		e of Death	
	/Medi	cal		enda Patr	icia Dolle					March	19	2006	7:20	) Ам	
Examiner			4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death  Doctors Community Hospital  Lanham								4c. County of Death Prince George's				
Funeral Director			5. Social Security Number 6. Se 214-60-4006	x 7. Ag ☐M 2 <b>[X</b> ]F	e (In yrs. last birtl		Under 1 Ye onths Da		Min.	8. Date of Birtl (Month, Day Aug 25	h /, Year) 5, 1950	9. Birth Co.	nplace (Sta untry) Maryla	te or Foreigr nd	
e, Marylan	ith the Maryland or 28a-f show	To Be Completed by Funeral Director	10a. State 10b. County  MD Anne A	rundel	10c. City, Town	or Location	Too. mode						City Limits		
	with the		10e. Street and Number 2088 Lake Grove Lane					10f. Zip Code <b>21114</b>				10g. Citizen of What Country? U.S.A.			
	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Is marked other then "neturel", or Iteme 23e or 28e-f show umatic event, I'm Medical Exercities trains be notified at		11. Marital Status  1 🕱 Never Married 2 🗆 Married  3 🗆 Widowed 4 🗀 Divorced	1. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X No H Yes Give				of Hispanic Origin? (Specify Yes or No- Cuban, Mexican, Puerto Rican, etc.)				4. Race - American Indian, Black, White, etc. Specify: Black			
			15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	15. Decedent's Education (Specify only highest grade completed)  ementary/Secondary (0-12) 1 College (1-4or 5+) 1 College (1-4or 5+) 1 Never Worked									ndustry		
			17. Father's Name (First, Middle, Last)	Enoch Henry	Hall		1101			e (First, Middle, Gol				-	
	Ith a		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  2088 Lake Grove Lane Crofton, MD 21114												
	0 0		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	lemoval from State		r, cremator	ry or other i	olace)		Date /25/06	20c. Loca	ation - City or 1			
Balti	permit. Pag Department Important: f any injury o once.		A Donation 5 Other (Specify)  Mt. Hope UM Church Cemetery 03/25/06 Sunderland, MD  21. Signature of Funeral Service Licensee Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 20678												
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Acute bronchopneumonia complicating urosepsis  Due to (or as a consequence of):										Between		
0,	Attending Physician: The law requires that the death certificate be executed rideath categories and sector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.												
P.O. Box 6876			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ★ Yo 9 □ Unknown	1 ☐ Live birth	. If yes, outcome of pregnancy  1 \( \text{Live birth} \) 2 \( \text{Fetal death} \) 3 \( \text{Ectopic pregnancy} \)  4 \( \text{Pregnant at time of death} \) 5 \( \text{Other (specify)} \)  9 \( \text{Unknown} \)									Year	
rds, P			Part II. D <b>ther significant conditions</b> contributing to death but not resulting in the underlying cause given in Part I.  Down Syndrome and Alzheimer's Disease					23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown							
Division of Vital Records,	: The law re cate has be page 2 sho									24a. Was a autops perform	med?	24b. Were autoprior to codeath?	ompletion o	s available cause of	
Vit	sician certifi rector		25. Was case referred to medical examiner?  1 ★ Yes 2 □ No	lospital:		_	10	3thor		Check only on					
on of	ding Phy After this funeral d		27. Manner of Death 1 🖾 Natural 5 🗆 Pending	28a. Date of Injury (Month, Day Year)  28b. Time of Injury (Month, Day Year)  28c. Injury at Work?  28d. Describe how injury occurred											
Divisi	i or Attencation after death Director:		2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	ury - At home, farn :. (Specify)						Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								9(s)				
	To the To the comp.		29b. Signature and title of certifier	`				onse number	Ε.			signed (Month,		)	
-			30. Name and address of person who co					treet,	Balt	imore,					
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2. 2	32. Registra	r's Signature	Y A	parks	P							

Registrar DHMH 17 Rev 1/2001

State

1629 Columbia Road, N.W. Suite 334, Wash. D.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

M.D.

32. Registrar's Signature

E. DeVaughn Belton,

31. Date filed (Month Day, Year)

			1 - For Stata Registrar	State of	Maryland	•	artmen tificat			and M		Rag. No.	36	10038	
	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of De Month	Day	Year	3. Time of Death	
	/Medic		FRANCES AGN		OOD				1 - 2 -	10 "	MARCH	12	2006	4:30 P M	
	Examin	ıĕr	4a. Facility Name (If not institution, given WILSON HEALTH C		oer)				Location of ERSBU				nty of Death ONTGOM		
					Age (In yrs. la	st birthday)	If Under		If Under		8. Date of Bir	th			
	Funeral Director			1 □ M 2 💢 F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da Feb 1	y, Year)	Year) Country)		
	ס		Usual Residence of Decedent												
	show	_	10a. State 10b. County	070.00		Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 SNo	
	8a-t	Scto		omery	Ge	rmant						40. 022			
	72 hours after death with the Maryland neturel; or Items 23a or 28a-t show ited Examble motified at	Funeral Director	10e. Street and Number 19520 Scenery D	rive			10f. Zip	Code	208	376		10g. Citizen d	ted S		
	eath	erai	11, Marital Status	12. Was Deced	ent Ever in U.S	3. 13. <sup>1</sup>	Was Dece	dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No		ace - Ameri		
"	r Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forc	es? ⊠No		f Yes, spec	cify Cuba	n, Mexican	i, Puerto	Rican, etc.)	В	lack, White,	, etc. White	
036	reli, o	þ	3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Date	es:		1 ☐ Yes	2L/1N0	Specify:			Spe	cify:	MILTCE	
21215-0036	72 hc	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	kind of wo	rk done d	during most	t of work	ing	16b. Kind of			
121	vithin ne. <b>hen</b>	mpi	Elementary/Secondary (0-12)	College (1-4	lor 5+)		00 NOT u		)			Tnatit	Natio	naı of Health	
2	Hygie thert nt, th		10 17. Father's Name (First, Middle, Las.	0		те	chnic	Lan	18. Mothe	er's Name	e (First, Middle,			or nearth	
ano	d be antal l	To Be		ullineau:	x				Agne		Harris		,		
Maryland	shoul nd Me mark	F	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rur	al Route Numb	er, City or Tov	vn, State, Zi	p Code)	
Ĕ	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. item 27 is marked other then "neturel", or items 23a or 28a-1 show cother treumatic event, If a Medical Excention ratio is natified at		James E. Hood / Son 19520 Scenery Drive, Germantown,											0876	
altimore,	of He ritem		1 🗵 Burial 2 Cremation 3 Removal from State										c. Location - City or Town, State		
ij	nit. Pages partment of ortent: It i injury or		1 Burial 2 Cremation 3 Hemoval from State 14 Donation 5 Other (Specify) Hyattstown Community 3/15/06									Hyatt	stown	, Md.	
Balt	permit. Pages 1 Department of H Importent: It ite eny injury or ot	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Muriel H. Barber Funeral Home													
ш	₹0 <b>=</b> ₹ a		P. O. Box 5038, Laytonsville, Md.  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											20882	
Р			shock, or heart failure. List only	one cause on eac	ch line.	. Do not ent	er the mod	ie or ayın	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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0	e exe ian ar urial-t		resulting in death) Last	Due to (or	r as a consequ	ence of):									
8760,	ate b	Physician/Medical		d											
9	leath certifica attending ph I for use as th	/Mec	IF FEMALE:	23c. If yes, outco	ome of pregnar	acv.						024	Date of dela		
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	th 2 Fetal nt at time of de	death 3[	Ectopic p						Date of deliv Month	Day Year	
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Δ.	es that the igned by be detact		Part II. Other significant conditions	contributing to dea	th but not resu	Iting in the u	nderlying o	ause giv	en in Part I		23e. Did t	obacco use c	ontribute to	the cause of death?	
rds	quires in sign	ed by	HYPERTEN	SION							10	Yes 2 No	3 ☐ Pro	bably 4 Unknown	
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ita	iclen: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Deat	h (Check only o	one)			
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no O	ding P	inol.;	27. Manner of Death  1 Natural 5 □ Pending	Il 5 Pending (Month, Day Year) Injury Work?								how injury occ	curred		
isi	death.	icat	3 Suicide 6 Could not	investigation M 1 Yes 2 No  Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Lo.								Street and Nu	m <i>b</i> er or Rui	ral Route Number,	
Division	l or Attendater deatl Director:	Certification;	4 ☐ Homicide determined	building	g, etc. (Specify	)	cot, ractor	y, onice			City or To	wn, State)		,	
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	To the Hospite within 24 hours To the Funerel completely filled	edical	(Check only 2 Medical Exa	minar: On the bas and manne		ion and/or in	vestigation	, in my o	pinion, dea	ith occur	red at the time,	date and place	e, and due t	to the cause(s)	
	To the To the comp	ž	29b. Signature and title of certifier	. 1			290	c. Licens	e number			29d. Date sig	ned (Month,	, Day, Year)	
	3		Merlyn	Vene	My M	W	ي ط	<i>USS</i>	> 14	/		3/14	-6		
			30. Name and address of person who	completed cause	of Leath (Item	23a) (Type,	Print)	VF	Su	ITE	227	SII	VER	SPRING	
			Melyn 30. Name and address oberson who M. VEMUK † M. 31. Date filed (Month, Day, Year)	32.60	nietrar'e Sinnat	NITO I	4 -		,	-		N	1) 2	09/12	
	Sta Registi		MAR 15	2006	gistrar's Signat	1						•		- ,02	

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 20, March 2006 6:45 p.m. Hurry Sayres Louise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Leonardtown St. Mary's Hospital If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5 Social Security Number Days **Funeral** Hours Min 1 ☐ M 2 🛣 F Yrs. West Virginia 236-16-9203 83 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural" or harmany injury or other traumers. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director Maryland St. Mary's Compton 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20627 United States 39848 Lady Baltimore Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White δ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coitege (1-4or 5+) 5+ School Teacher Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rhuhama Ivy Mahaffy Silas Elsworth Sayres 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 302, Clements, Maryland 20624 Sue Blackwell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 DBurial 2 Cremation 3 Removal from State St. Joseph's Cemetery 3-24-2006 Morganza, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Em **Physician** phy semo /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician Be Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Day Year Month detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 No 2 🗹 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending 1 Naturai 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To tha Funaral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month), Day, Year) 29c. License number 29b. Signature and title of certifier 2 052815 66 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel Alexander, M.D., 25500 Point Lookout Road, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32\_Registrar's Signature State MAR 2 2 2006 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Holley, Jr. March 19, 2006 1:50 A 0scar Robert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 11€ M 2 □ F Yrs. 218-24-6996 Director 78 Sept. 10,1927 Maryland Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28e-f show other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No St. Mary's Charlotte Hall Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or itsms 23s 29066 New Market Village Road 20622 USA Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 █No If Yes, Give Year or Dates: t Never Married 22 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🔀 No Completed by 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within is Department of Health and Mental Hygiene. Important: if item 27 is marked other than \*? any injury or other traumatic avant, the Mad once. Elementary/Secondary (0-12) than College (1-4or 5+) Laborer Tree Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert 0scar Holley, Sr. Nettie Shorter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20622 19a. Informant's Name/Relationship (Type, Print) 29066 New Market Village Rd., Charlotte Hall, MD Marian Holley/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 3/22/2006 4 ☐ Donation 5 ☐ Other (Specify) All Faith Episcopal Charlotte Hall, MD Brinsfield-Echols Funeral Home MD P 20622 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial infarction **Physician** /Medical Due to (or as a consequence of): Examiner 10 years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner 14 years Hypertension/Diabetes or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Dementia (Alzheimer) 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown (Stroke) Vascular Ac. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 ☑ No 1 Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cepties 29d. Date signed (Month, Day, Year) 29c. License number DO 2159 March 21, 2006 Gua

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of perso

31. Date filed (Month, Day,

Eugene Gyazzo,

Year)

Dr.

ORIGINAL

Chaptico, Maryland

tho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

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State of Maryla	and / Department of H	lealth and Menta	al Hygiene	anne

		•	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of			ene () () g. No.	6	10041	
	Physici		Decedent's Name (First, Middle, La     Jeffrey	Andrew	Н	licks		2. Date of Death Month March		006	3. Time of Death 11:17 AM	
).	/Medio Examin		4a. Facility Name (If not institution, giv			4b. City, Town, o	or Location of Death		4c. County			
			1296 Steamboat Ro	·		Shady S		1	Anne			
ì	Funeral Director		134-30-2000		e (In yrs. last birthday 60 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 4,	<sup>Year)</sup> 1945	9. Birthp Cour New	place (State or Foreign htry) Jersey	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits	
	Mary	tor	MD Anne Ar	unde1	Shady	Side					1 □ Yes 2 □ No	
	or 28g	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?	
	ath wii		1296 Steamboat	Road		207			USA			
aryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiane. Is marked other than "natural", or Itema 23e or 28e-f ehow aumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces?  1 XYes 2 1 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cubin 1 ☐ Yes XXNo	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		k, White,	ean Indian, etc. White	
2	72 ho	eted	15. Decedent's En (Specify only highest gra	ducation	16a. Dece	edent's Usual Occup	during most of work	ina 1	6b. Kind of Bu	usiness/In	dustry	
2	vithin ne. hen	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retire	d)	9	C	_ 3		
0 0	filed v Hygia ther t		17. Father's Name (First, Middle, Last,	)	Fore	man	18. Mother's Nam	e (First, Middle, M	Seafo			
<u>a</u>	lid be lental ked o	To Be	Bertram C. Hick	S			Phy11is	King				
ary	shou and M s mar		19a. Informant's Name/Relationship (	Туре, Print)	19b. Mail	ing Address (Street	and Number or Run	al Route Number,	City or Town,	State, Zip	Code)	
≥	and 2 ealth a n 27 i		Beverly H. Cron	(Sister)			nock Dr.,		-			
altimore,	Pages 1 nent of Hi int: If iter iry or oth		20a. Method of Disposition 1 ☐ Burial 2 【**Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other plac			Oc. Location -	City or To	own, State	
Ē	t. Pag trent: rient:	,	4 □ Donation 5 □ Other (Specif	(y)	Metro Cr		1		altimo	re, l	MD	
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic e once.		21. Signature of Funeral Service Licer	1500	2		y Funeral 19 Sy Avenue			D 214	401	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying	a. OHUM Due to (or as	the death. Do not ene.  Disclosion a consequence of):	$\alpha$	ng, such as cardiac				Approximate Interval Between Onset and Death	
68760,	tificate be executed ig physician and as the burial-transit	ledical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):							
P.O. Box	Attending Physician: The law requires that the death certific death.  •ctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Completed by Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnance □ Other (specify) _	у			23d. Date of delivery Month Day Year		
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Division of Vital Records,	The law requirence has been sinage 2 should l	omplete	3 3					24a. Was an autopsy perform 1X Yes 2	ed?	prior to co death?	psy findings available mpletion of cause of	
<u> </u>	ilan: artifica ctor, p	Bec	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one				
<u>&gt;</u>	hysic this ce at dire	2	1 X Yes 2 □ No		ont 2 ☐ ER/Outpatie	INI SEL DOM		me 5 Resider			at scene	
ב	Jing P	lon:	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time ( y Year) Injury	Wo		28d. Describe how	v injury occuri	red		
Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street City or Town, Street)								al Route Number,	
_	ne Hospital or At 24 hours after of the Funeral Direct lietely filled in by	Medical Co		nysician: To the best niner: On the basis of	examination and/or in							
	To the within 2 To the complet	Mec	29b. Signature and fill of certified	and manner sta	atod.	29c. Licens	se number	29	d. Date signe	d (Month,	Day, Year)	
)	->-0	1	IN leh	$\sim M$		0.	C.M.E.		March 1	13, 2	006	
()em			30. Name and address of person who	completed cause of d	eath (Item 23a) (Type	Penn Str	eet, Balt	imore, Ma	arylano	1 212	.01	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 6	32. <b>Bé</b> gistr	ar's Signature	barde						

Kobin A. Harrenton 06**-1**890 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,PTT 27 penMarytand 4/37/06 tTT of Health and Mental Hygiene AKG 10042 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** ROBIN ANN HARRENTON March 17, 2006 5:52 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Memorial Hospital Prince Frederick

If Under 1 Year | If Under 24 Hrs. Calvert 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M XXXF 212-02-9594 40 Yrs. Director 28,1965 WASH.,DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Moule !7 is marked other then "natural", or Iteme 23a or 28e-1 eho: treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ∑No CALVERT Director MARYLAND LUSBY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12396 ALGONQUIN TRAIL 20657 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedenf of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, efc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify: Specify: þ WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN SELF ges 1 and 2 should be filed t of Health and Mental Hygi If Itam 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT HUDSON MARY JANE NEWMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL HARRENTON-HUSBAND 12396 ALGONQUIN TRAIL, LUSBY, MD 20657 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Stafe Pages tXDBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Pag Depertment Important: It eny injury o 4 ☐Donation 5 ☐ Other (Specify) TRINITY MEMORIAL GDNS. 3-23-06 WALDORF, MARYLAND 21. Signature of Funeral Service Licensee M00479 42. Name and Address of Facility FUNERAL SERVICE, P.A. RAYMOND 23a. Part1. Enter the disease, or complications that clused the death. District the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causing each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf Physician Complications of chronic alcoholism disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Secure field is a model in sife any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ģ Division of Vital Records, P. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Atherosclertoic cardiovascular disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of sath?

1X Yes 2□ No 24a. Was an has page 5 autopsy performed? certificate 1 Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) tXYes 2 □ No 3□ DOA ဥ 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury af Work? 28d. Describe how injury occurred After Certification: Hospital or Attending Injury 1 XNatural 5 Pending after death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. March 18, 2006

Registrar
DHMH 17 Rev 1/2001

State

111 Penn Street, Baltimore, Maryland

f person who completed cause of death (Item 23a) (Type, Print)

32 pegistrar's Signature

RIAPUEMO

2006

31. Date fied (Month, Dily, Year)

MAR 3 1

Registra

NLM .\_\_\_ 06-01680 Har

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a 27, 28a-f, pen/f, 0524, 4/5/00 TT

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у Јо	ohnso	n	For State Registrar	State of M	aryland /		irtment of F tificate of		Mental Hy	/giene Reg. No		10089
	Dhysici	20	1. Decedent's Name (First, Middle, La	st)					2. Date of D Month	Da		3. Time of Death
	Physici Medio/			hnson					Marc	ch 8	, 2006	3:55 P™
	Examir	er	4a. Facility Name (If not institution, given				•	r Location of Death	n	40	. County of Death	
			6849 Sturbridge		- //	history a	Ba.	ltimore   If Under 24 Hrs.	1.0	-1	0.00:45	
	uneral irector		5. Social Security Number 577-70-5504  Usual Residence of Decedent	Sex 1 M 2 □ F	je (In yrs. last 51	Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D 05-11-	1954	y Birms Cour 4 Washi	place (State or Foreign ntry) ington, D.(
land	A II		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
within 72 hours after death with the Maryland ene.	Ba-f eho	Director	D.C.			Wash	ington					1∭ Yes 2 ☐ No
vith t	or 2	Dire	10e. Street and Number	T #0			10f. Zip Code 20002	)		_	itizen of What Coul S . A .	ntry?
ath	8 232	rai	2115 I Street, N	E. #2	Free in II C	10.1					14. Race - Americ	oon ladias
urs arrer de	er, or item Examiner	by Funeral	11. Marital Status  1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 (X)Yes 2 (1)  If Yes, Give Year or Dates:	)		Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerti Specify:	o Rican, etc.)	Black, White, etc.  Specify: Black		
72 ho	in i	ted	15. Decedent's E (Specify only highest gr	ducation	16	6a. Deced	lent's Usual Occup	ation during most of wor	king	16b. K	Cind of Business/In	idustry
ithin 7	Hygin that	Completed	Elementary/Secondary (0-12)	College (1-4or		lite. L	DO NOT use retired	d)	Kii ig	Un 1	tor Pood	Hospital
filed v Hvaje			8th 17. Father's Name (First, Middle, Last	<b>.</b>	P	laint	enance	18. Mother's Nan	na (First Middle			Hospital
o De	o po	o Be	John L. Johnson	,					Wilson	s, maider	, Sumumo,	
and Men	mark	၉	19a. Informant's Name/Relationship	Type, Print)	1	9b. Mailin	a Address (Street			ber, City	or Town, State, Zip	code)
alth a	27 ls		Quiana K. Varner	/daughter	( I	041/ Distr	Hil Mar ict Heir	Drive #20 hts, Mar	vland,	2074	7	
He	r other t		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐	35	20b. Place		sition (Name of natory or other place		Date		ocation - City or To	own, State
neut	ing in		4 □Donation 5 □Other (Speci			tico	Nat'1 Ce	m. 03-2			angle, V	
Departm	important: If ite		21. Signature of Funeral Service Lice	C, Ba	Con						neral Horgton, D.(	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each l	d the death. D	o not ente	er the mode of dyin	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
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cate	physic	d								- 1		
	ttendin o use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   23d. Date of delivery   Month   M									ery Day Year
	n signed by the a uld be detached f	6	Part II. Other significant conditions	contributing to death t	out not resulting	g in the ur	nderlying cause giv	en in Part I.		tobacco		the cause of death?
	sate has been si page 2 should t	Completed							24a. Wa auto peri	s an opsy formed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
r death.	certificate rector, pag		Ac W						1□ Yes	2 🗆 No	o 1 ☐ Yes	2 No
		o Be	25. Was case referred to medical examiner?  1 3/Yes 2 No	Hospital:	0 C CD	Outpatien	Oth	er: 4 Daysein H			e ViOthas (Casa)	h) At Scene
	er this eral di	7: To	27. Manner of Death	28a. Date of Inju	ıry 28t	o. Time of	1 3D DOA	4   Nulsing I	lome 5 Res 28d. Describe			y At Scene
ath.	r: Afte	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Da n End 3/8/20		Injury 1k		Man ONT MAN	unk			
ter de	Diractor: J	Certification;	3 ☐ Suicide 6 🖾 Could not be determined	286. Place of in	jury - At home, tc. (Specify)	, farm, str	eet, factory, office		28f. Location City or To	(Street a	nd Number or Rura	rbridge Dr.
urs af	led ir			apartment					Art. B Ba	altimo	ore, MD	
24 hou	To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis of and manner st	of examination	dge, death and/or inv	occurred at the tir restigation, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time	e cause(s e, date an	s) and manner as s nd place, and due t	stated. to the cause(s)
III)	To the	Me	29b. Signature and title of certifier	wind illustrated St			29c. Licens	e number		29d. Da	ate signed (Month,	Day, Year)
1			· aust		A 0: 27	-) (7	2	O.C.M.E		Mar	ch 9, 20	06
	U		30. Name and address of person who	completed cause of	peath (Item 23	a) (iype,	•	nn Ctroo	+ Pol+4	moro	e, Maryla	nd 21201
	Sta	ite	31. Date filed (Month, Day, Year)	1	rar's Signature			enn Stree	u Daltl	шоге	, пагута	114 21201
	Registi		MAR 2 8 200	6 Men	rar's Signature	Ann						
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DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Marylar			t of He		Me		giene Reg. No.	006	10045		
	Physici	an	Decedent's Name (First, Middle, Last	")					2.	Date of Dea Month	ath Day	Year	3. Time of Death		
	/Medi			ohnson						March	10	2006	4:55 A <sup>M</sup>		
7	Examir	ner	4a. Facility Name (If not institution, give			4b. City,		ocation of De			4c.	County of Death	n		
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	Funeral		5. Social Security Number 6. Se	XM 2 TF	Ven	Months		Hours Mi	n.	Date of Birt (Month, Da	y, Year)	(Year) Country)			
	Director		212-48-7075 Usual Residence of Decedent	5.	9				O	ct. 31	, 19	146 Ma	ryland		
	land ow		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits		
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	r 28s	Director	10e. Street and Number	ocorge 5		10f. Zip		JI HEL	gues		10g. Citi	zen of What Cor	untry?		
	13a o	0	206 Shady Glen	Drive			2	20743				United	States		
	deat ma	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dece		anic Origin? Mexican, Pue	(Specif	y Yes or No		14. Race - Amer	ncan Indian,		
9	or it		1 ☐ Never Married 2 ☑ Married	1 ⊠Yes 2 □ No If Yes, Give		1 ☐ Y <i>e</i> s		Specify:	ento mic	an, etc.,		Black, White			
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f ehow fra Medical Exercities roust be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		103	290110	эрвону.				Specify: B	lack		
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121	hen hen	I d	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT u	se retired)								
2	lled v Hygie ther t		17. Father's Name (First, Middle, Last)	2	l	Ca	rpente	er 3. Mother's N	ama /F	imt Middle		elf-Emp	loyed		
anc	nould be filed within a Mental Hygiene. nerked other than natic event, the M	Be					16	S. MOLTIEFS IN	ame (r						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Heelth and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic avent, the Medical Exercities invalike incilling at	2	Samuel Jo		105 14-15		(0)	4.44	0 1 0			e Parke			
Ma	12 sl h an 7 is r		Angela C. Mine		1	_		Ct.,			-	Town, State, Z	ip Code)		
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Bal	permit. P Departm Importar eny injui		21. Signature of Funeral Service Licens		ے ا		nd Address o					ral Hom			
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Вох	leath certifica ettending ph ifor use as th	N.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna								23d. Date of delin	verv		
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Ö	w requir been s should	ete							ï	24a. Was	an	24b. Were aut	topsy findings available		
Re	The lay	autopsy prior to comple performed? death?										ompletion of cause of			
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ō	Physic this seal di	<b> -</b>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		28c. Injury at Work?			. Describe h		3 □Other (Spec y occurred	ary)		
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Division	il or Attending efter death. I Director: After d in by the funer	Ę	3 ☐ Suicide 6 ☐ Could not be	28e. Place of injury - At n	ome, farm, str	eet, factor	y, office		28f		Street an	d Number or Ru	ral Route Number,		
á	F 8 F C	Certification;	4  Homicide determined	building, etc. (Specif	<b>y</b> )					City or Tou	m, State,	)			
	To the Hospital c within 24 hours of To the Funeral D completely filled in		29r Certifier 11 Certifying Phy	nsician: To the best of my kno	wiadge; death	i Geeumed	at the time,	data and pla	ee, and	due to the c	13,050(8)	and tranner se	etatad.		
	n 24 n 24 n F.	edical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ition and/or in	vestigation	, in my opini	ion, death oc	curred	at the time, o	date and	place, and due	to the cause(s)		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	1 100			c. License n	<i>p</i> * .			29d. Dat	e signed (Month	n, Day, Year)		
			VP/IIV				0006	188	2			March 1	3. 2006		
0	(5)	- 88	30. Name and address of person who co	ompleted cause of death (Item	n 23a) (Type,			- /	7			raich 1.	2, 2000		
_				n, M.D. 1500 H			Road.	Silve	er S	pring	, MD	20910	-1484		
	Sta	ite	31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature		,				, -12				
Q.	Registr	ar	MAR 1 7 2006	Electron &	6000	(a)									

State of Maryland / Department of Health and Mental Hygiene () 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 11:46 A M Physician 06 2006 RODNEY MARCH JONES /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** GEORGE PRINCE MARYLAND HOSPITAL SOUTH ERN CLINTON 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 XM 2□ F Yrs 22, 1953 Wash. Director 577-74-3003 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County ed other than "naturel", or iteme 23a or 28a-f ahow avent, the Medical Examinar must be notified at 1X Yes 2 ☐ No Director Forestville Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 20747 United States 6120 Surrey Square #203 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: if Item 27 ie marked other than "naturel", or Iteme 23. ury or other traumatic event, the Medical Exemple Hithest by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🛛 No 1 X Never Married 2 ☐ Marned 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Black Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Medical Assistant Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grafton Willie Jones Vasca R. Johnson P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6120 Surrey Sq., #203, Forestville, MD Vivian Jones/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department Important; If any injury of Lee's Crematory 3/18/06 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee 4001 Benning Rd., N.E. Wash., DC 20019 Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) circulatory failure falline, 6 day 8 **Physician** Respiratory /Medical Due to (or as a consequence of): of pontine of midbrain & daiy Examiner extensive cerebella Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner & day physician and s the burial-transit The taw requires that the death certificate be executed union holled CVA Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No HTM. CAD, CVA. Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2/2/No 1 🗌 Yes o the Hospital or Attending Physician: After this certification, 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af investigation 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 THomicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M58141 03/07/06 Vilaman M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHINTON - MD - 208/35 7503 SURRATIS ROAD VIJAY SITRI KANNAN 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 1 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State
Registre3-20-06Amend#4a.PerPhys.PCCC Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2. A M GENEVIEVE 2006 03 /Medical 4a. Facility Name (If not institution, give street and number of interesting home & Renab 4c. County of Death 4b. City, Town, or Location of Death **Examiner** P.G. CLIMTON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 202 F Months Carolina 207-20-2381 Director 22-1916 South Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 27 is marked other then "neturel", or Items 23s or 28s-f show treumetic event. The Medical Examinativities to institled at tyE Yes 2 □ No Director PG Temple Hills Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4005 Danville Drive 20748 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Twidowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Nurse Private 18 Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be fund Mental I Charles Burrows Maria Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) d 4005 Danville Drive
Tomple Hills, Maryland
20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 and 2 sl ment of Health and ant: If item 27 ls r Patricia A. Green/friend 20748 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Crematory 3/18/06 Riverdale, Md. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** Venescleration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 Other (specify) 4☐Pregnant at time of death signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ should be 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ②【 No 24a. Was an autopsy performed? page 2 1 Yes certificate 2 X No or Attending Physicien: funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) examiner Other: 412 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03-20-06 145365 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Sidarous, M.D., G. 11701 Livingston Rd. #101, Ft. Wash., Md.

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 2 0 2006

			-	State of Maryland		nent of He			iene <sub>eg. No.</sub> 0 0	6 10048
	/M	sicia: edica	n al -	1. Decedent's Name (First, Middle, Last)  Nadine P. Jarma		-		2. Date of Deat Month	8-06	Year 3. Time of Death //: 35 PM
		mine	3	4a. Facility Name (If not institution, give street and number)  Atlantic General Hospita  5. Social Security Number 6. Sex 7. Age (In yrs. la	i/	Berli	ocation of Death  Output  Outp	8. Date of Birth		9. Birthplace (State or Foreign Country)
	Fune Direc			220-26-1370 1 M 2X F 75 Usual Residence of Decedent	Yrs. Mo	onths Days	Hours Min.	8. Date of Birth (Month, Day, 5/12/19	930	MD
	a Marylan a-f show	TE SAIII			, Town or Locatio erlin	n				10d. Inside City Limits 1 ☐ Yes 🏖 🛣 No
	ath with the Marylan 23e or 28e-f show		Funeral Director	10e. Street and Number 107 Cedar Ave.	10	Of. Zip Code $21811$		1	0g. Citizen of W USA	
OL			by Funer	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes	Decedent of His s, specify Cuban res 2 2 No	panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White
-13	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after de Health and Mental Hygiene. them 27 is marked other than "natural", or trampted.		Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind	s Usual Occupat of work done du IOT use retired)	ion iring most of work	ing	16b. Kind of Bus	siness/Industry
90	Maryland 2121 d 2 should be filed within th and Mental Hygiene. the marked other than	auc avant.	lo Be C	17. Father's Name (First, Middle, Last)  Vernon Powell				et Rogei	Maiden Surname	e)
_	Te, Mar 1 and 2 shi Health and tem 27 is m			19a. Informant's Name/Relationship (Type, Print)  George R. Jarman	11546 M	lumford	Rd., Bis	hopville	MD 21	813
	Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2	no or or		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State	ace of Disposition Imetery, cremator Igreen C	y or other place, Cemetery	3/2	2/2006	Berlin,	
\$\$ <del>#</del>	Ball permit. Depart Import	once.		21. Signature of Fundal Service Licensee	108	Willia	of Facility Th m St., B	erlin, M	ID 21811	
70000/31	Syedy  Sate be executed  Weddie  Examin  Examin  Hophysician and  Hophysician and	cal ner	Ical Exa	23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the consequ	ence of):	e mode of dying,	such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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1, 02 P 330 D	Cords, vrequires been sign		Completed by Pr	Part II. Other significant conditions contributing to death but not result Clostridium dificile in for			n in Part I.	1 7 Ye	n 24b. W	bute to the cause of death?  3 Probably 4 Unknown  Vere autopsy findings available for to completion of cause of
DON'S STORY	f Vital Reversition of the law is certificate has		e a	Chonic obstructive pulmo 25. Was case referred to medical examiner?	- 4		26. Place of Deat		ned? de 2 No 1 l	eath? ☐ Yes 2 ☐ No
mas: 05/	On O		Certification: 10	1 Actural 5 Pending (Month, Day Year)	28b. Time of Injury	28c. Injury a Work? d 1 ☐ Ye	4 Nursing Ho	28d. Describe ho	ow injury occurre	ed
780	Division o To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director, After the		al Cerum	4 Homicide determined 299. Place of injury Action building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my know	) vledge, death occ	curred at the time	, date and place,	City or Town	n, State) ause(s) and man	r or Rural Route Number,
	To the H within 24 To the F	and and	Medical	one) and manner stated.  29b. Signature and title of certifier	on and/or investig	29c. License	number (のど	) 2	9d. Date signed	(Month, Day, Year)
8	i Est	8		30. Name and address of person who come feted cause of death (Item KRISTINE GRIFFIN, MO 1209 C		()	06795 WAY FI		3-19-0 ISLAN	
	The second	State sistra		31. Date filed (Month, Day, Year)  MAR 2 0 2006  32. Jegistrar's Signatu	by Span	es es	0.1, 12	<i>y</i> - 0 0 0 . 0 1	734.00	, , ,

State of Maryland / Department of Health and Mental Hygiene. UU b 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** Sarah Zell Jackson 19, 2006 0300 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital If Linder 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 1 □ M 2 🖸 F 97 1908 Pennsylvania Director 219-74-1606 July 16, Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Director Cecil Perryville Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1122 Susquehanna Avenue 21903 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: If Yes, Give Year or Dates: Completed by White 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2121 Cotlege (1-4or 5+) Elementary/Secondary (0-12) Eight Years Homemaker Personal Residence 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be l end 2 should be lealth and Mental David Zell Olive Benjamin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Retationship (Type, Print) Health Anna M. Skinner (Daughter) 1914 Juniper Road, Edgewood, Maryland 21040 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
eny Injury or ot
once. 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State Asbury Cemetery 03/22/06 Port Deposit, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21933-766 CHE YOU , W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PWEYMMIA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner TOPARLTION MYCHOLIN Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit 1 1 CHUENSIDI that initiated events resulting in death) Last ue to (or as a consequence of) Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy r this certificate had rail director, page 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 1 inpatient 2 ER/Outpatient 3 DOA ို erel Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: tnjury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide l or A To the Hospital within 24 hours a To the Funerel D 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 19106 4im D46411 Name and address of person who completed cause of death (Item 23a) (Type, Print) PhD H106 5. Mylon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 0 2006

ackson,

Sin

JC 06-02016 James W. Kemer

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ite gistrar	Certificate of Death	Reg. No.	101 101	1 10	
r er	State of Maryland / Department of Health and Mental	Hygiene	006	10	Manage Comments

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. important: If Item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours efter death.

To the Funerel Director: After this certificate has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760,

1	For State Registrer		bartment of Health ertificate of Death		Hygier Reg. I	the left to	16	10050		
	Decedent's Name (First, Middle, Last)	1		2. Date o	Death			3. Time of Death		
n	James Wilson Kemerer			Month March		Day 20	$0^{\text{Year}}$	06:46 AM		
il r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County				
	42 nd Ave. & Oglethorpe		Hyattsville			Prince George's				
	5. Social Security Number 6. Sex 7. Age (In	yrs. la'st birthday	() If Under 1 Year   If Under	r 24 Hrs. 8. Date o				place (State or Foreign intry)		
	168-22-2525 <sup>1⊠M 2□F</sup>	78 Yrs.	Months Days Hours	Min. (Month	21,	1928		nsylvania		
	Usual Residence of Decedent									
_		c. City, Town or t	Location					10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
20		lyattsvi			.,					
	10e. Street and Number		10f. Zip Code		10g.	Citizen of \	What Cou	intry?		
8	4211 Oglethorpe Street		20781		U.S	5.A.				
rue	11. Marital Status 12. Was Decedent Eve Amed Forces?	r in U.S. 13	<ul> <li>Was Decedent of Hispanic O</li> <li>If Yes, specify Cuban, Mexica</li> </ul>	rigin? (Specify Yes o an, Puerto Rican, etc.	r No- )		e - Ameri ck, White	ican Indian, , etc.		
<u>ک</u>	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ☐ Yes 2 ☒ No Specify	<i>r</i> :		Specif	v: Wh	ite		
Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced Year or Dates:				1					
lete	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupation re kind of work done during mo DO NOT use retired)	st of working	16b	. Kind of B	usiness/lr	ndustry		
Ē	Elementary/Secondary (0-12) College (1-4or 5+)		ŕ		11			- F. Man-1 am		
3	12 17. Father's Name (First, Middle, Last)	Post	al Clerk	ner's Name (First, Mic				of Maryland		
Re										
9	Henry Lawrence Kemerer	10h M-		e Gail Kl				- O- 4)		
	19a. Informant's Name/Relationship (Type, Print)  Alice Ward - Daughter		lling Address <i>(Street and Nu</i> m <i>l</i> 5 Old Fletcher							
		20b. Place of Disp		Date				own, State		
	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cr	ematory or other place)				-			
			coln Cemetery							
	21. Signature of Funerat Service Licensee		22. Name and Address of Faci							
	( almis/ /m/h > 5101	373	4739 Baltimo	re Avenue	, Нуа	ittsvi	ille,	MD 20781		
	23a. Part1. Enter the disease, or commications that caused the shock, or heart failure. List only one cause on each line.	death. Do not e	nter the mode of dying, such a	s cardiac or respirato	ry arrest,			Approximate Interval Between		
OV	Immediate Cause (Final disease or condition Arterioscle	erotic can	diovascular diseas	se				Onset and Death		
	resulting in death)  Due to (or as a co	onsequence of):	77.	-						
	Sequentially list conditions, b.									
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am	Cause (Disease or injury that initiated events c.									
ŭ	resulting in death) Last Due to (or as a co	onsequence of);								
20	d.						_			
Se l	IF FEMALE:									
Completed by Physician/Me	23b. Was decedent pregnant 23c. If yes, outcome of p		☐Ectopic pregnancy			1	te of deliv	1		
200	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)		-	Mic	enth	Day Year		
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2	Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying cause given in Part					the cause of death?		
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E				1/27	utopsy erformed es 2 🗆	?	deathr? 1. DYYes	2 No		
De C	25. Was case referred to medical		26. Plac	ce of Death (Check o		140	7	2010		
0	examiner? 11☑ Yes 2☐ No Hospital: 1 ☐ fnpatient	2 ER/Outpatio	Other	lursing Home 5 🗆 I		6 <b>V</b> IOth	er (Snec	by Scene		
_	27. Manner of Death 28a. Date of fnjury	28b. Time	of 28c. Injury at	28d. Desci						
	1 X Natural 5 ☐ Pending (Month, Day Ye 2 ☐ Accident investigation	ea <i>r)</i> Injury	M 1 Yes 2	]No						
IIC	3 Suicide 6 Could not be determined 28e. Place of Injury	At home, farm, s	street, factory, office				er or Rui	ral Route Number,		
P	4 Homicide determined building, etc. (S	pecity)		City of	Town, St	a(0)				
Medical Certification:	29a. Certifier (Check only)  Medical Examiner: On the basis of examiner and manner stated	amination and/or i	ath occurred at the time, date a investigation, in my opinion, de	and place, and due to path occurred at the ti	the cause me, date	e(s) and ma and place,	anner as and due	stated. to the cause(s)		
Σ	29b. Signature and title of certifier		29c. License number		29d.	Date signe	d (Month	, Day, Year)		
	1 & lokemed							oate signed (Month, Day, Year) rch 23, 2006		
	30. Name and address of person who completed cause of death						1100			
4	I Man wike MU	111 P	enn Street, Ba	ltimore, l	Maryl	and 2	21201			

State Registrar

31. Date filed (Month, Day, Year)

MAR 2 8 2006

32. Registrar's Signature

Box 68760 Division of Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certific completely filled in by the funeral director.

State Registrar

DHMH 17 Rev 1/2001

Medicai

31. Date filed (Month, Day, Year) MAR 2 0 2006

Lum

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a, Certifier

1126

(Check only one)

29b. Signature and title of certifier



M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

RES-000

29d. Date signed (Month, Day, Year)

il

2006

MARCH

			1- For Amend Item 8 per 1- State Registrar	а <b>ннусы 99</b> у <b>19</b> 9/1 <b>9</b>	Decline inc. Ensure  Postingent of Health an  Certificate of Death	d Mental Hygie	•	10052
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Ila Marie Kano	de		2. Date of Death Month	Day Year	3. Time of Death
	Examir Funeral		4a. Facility Name (If not institution, give stree  DOTCHESTER (7 PM  5. Social Security Number  232-11-0681	ral Hospital	Months Days Hours I	Hrs. 8. Date of Birth	4c. County of Deat	h hplace (State or Foreign untry)
	Director		232–44–0684	90 Yr	s.	Min. 09/13/19		t Virginia  10d. Inside City Limits
3	r 28a-f sh	Funeral Director	MD Dorchest  10e. Street and Number	er	Cambridge	10g	. Citizen of What Co	1 XYes 2 □ No untry?
2	death with	erai D	921 Race St.	/as Decedent Ever in U.S.	21613	? (Specify Yes or No-	USA	rican Indian,
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel', or Items 23e or 28e-f show entry injury or other treumatic event, the Medical Examination until be indiffied at once.	by	1 Never Married 2 Married 1	med Forces?  ☐ Yes 2 1 No Yes, Give ear or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 ☑ No Specify:	uerto Rican, etc.)	Black, White	white
21215-0036	within 72 h ene. then "natu	Completed	15. Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12)  11	npleted) (6	ecedent's Usual Occupation Give kind of work done during most of ife. DO NOT use retired) clerk	working 16	b. Kind of Business/ drugsto	•
Maryland 2	should be filed and Mental Hygis marked other imatic event, II	To Be Co	17. Father's Name (First, Middle, Last) William A. Noble		18. Mother's	Name (First, Middle, Ma		
	and 2 should ralth and Men n 27 is marke er treumatic		19a. Informant's Name/Relationship ( <i>Type</i> , <i>P</i> Paulette Watkins		Mailing Address (Street and Number o		City or Town, State, 2 21613	lip Code)
Baltimore,	permit. Pages 1: Department of He Importent: If iten eny injury or oth		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	val from State cemetery,	risposition (Name of crematory or other place)  Lry Crematory 3/		c.Location - City or Salisbury,	
Balti	permit. Departr Importe eny inju		21. Signature of Funeral Service Licensee		22. Name and Address of Facility 700 Locust St.,			P.A.
	Pnysician /Medical Examiner	- E	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clisses or in jury)	ns that caused the death. Do not use on each line.  Due to (or as a consequence of)	55	diac or respiratory arrest	,	Approximate Interval Between Onsor and Death
68760,	Attending Physicien: The law requires that the death certificate be executed refath.  redath. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	ledicai Examiner						
P.O. Box	uires that the death certific signed by the attending p d be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 ments? 1 □ Yes 2 No. 9 □ Unknown  23c. If 4 9 9		23d. Date of deli Month	very Day Year		
Records, F	w requires that been signed should be det	by	Part II. Other significant conditions contributed Type II. DiAB	ing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
al Rec	iicien: The law i certificate has bi rector, page 2 st	Completed	Anemia, Renal 25. Was case referred to medical	FAILUCE	sian, Mecnicia	24a. Was an autopsy performed	prior to c	topsy findings available completion of cause of
n of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	on: To Be	examiner? 1 Yes 2 Hospit	al: 15 Inpatient 2 ER/Outpa a. late of Injury (Month, Day Year) 28b. Tim	atient 3 DOA Other: 4 Nursin	Death (Check only one)  g Home 5 Residence 28d. Describe how		ify)
Division of	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Certification:	2 Accident investigation	e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No , street, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical C	(Check only 2 Medical Exeminer: C	: To the best of my knowledge, on the basis of examination and/ond manufer stated.	leath occurred at the time, date and plor investigation, in my opinion, death o	ace, and due to the caus courred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To t To t com	Σ	29b. Signature and title of certifier.	1-120	29c. License number 446	15 <sup>29d.</sup>	Date signed (Month)	(Day, Year)
			Lois A. Narr, D.O.	/	pe, Print) le St., Cambridge	, MD 21613	11	-
n de	Sta Registr	_	31. Date filed (Month, Day, Yeal)	32. Registrar's Signature	books			

_			1- For Amend Items State of Maryland / Department of Health and State of Werb, G853, 03/31/06dbb Certificate of Death		<del></del>	5 10053
	Physici		1. Decedent's Name (First, Middle, Last)  Ronald Dewayne Kells	2. Date of De Month March	Day	Year 7:00 A.M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deat		4c. County	of Death
			504 Beards Hill Road  Aberdeen  5. Social Security Number  6. Sex  7. Age (In vrs. last birthday)  If Under 1 Year   If Under 24 Hrs	Dota of Bio	Harfo	
	Funeral Director		215-28-5613 XX M 2 F 73 Yrs. Months Days Hours Min.		1000	Birthplace (State or Foreign Country)  Pennsylvania
	land w ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary m-f sh	tor	MD Harford Aberdeen			1 XYes 2 No
	3a or 28	i Director	10e. Street and Number 10f. Zip Code 21001		10g. Citizen of W	Vhat Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Item Medical Examination must be notified at	by Funerai	11. Maritat Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer Year or Dates: Korea	Specify Yes or No to Rican, etc.)	14. Race Blace Specify.	e - American Indian, k, White, etc. White
2-0	72 ho	sted	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wo	nkina	16b. Kind of Bu	siness/Industry
2121	within jiene.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Give kind of work done during most of wo life. DO NOT use retired)  Postal service	rnig	U.S. Po	stal
Maryland 21215-0036	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be C		me (First, Middle Benson	, Maiden Sumam	θ)
	and 2 shou alth and N 127 is mar ar traumat		19a. Informant's Name/Relationship (Type, Print)  Juanita Stuchinski (Friend)  19b. Mailing Address (Street and Number or Relationship (Type, Print))  504 Beards Hill Road			State, Zip Code) Yland 21001
Baltimore,	8 = 5		20a. Method of Disposition  1 \textbf{XBurial} 2 \textsuperscript{Cremation} 3 \textsuperscript{Removal from State}  1 \textsuperscript{Disposition} 5 \textsuperscript{Other (Specify)}  20b. Place of Disposition (Name of cemetery, crematory or other place)  Harford Mem. Gdns. 3/27	Date 7/06		City or Town, State on, Maryland
Balti	permit. Pa Dep. rtmen Imp. rtant: any injury once.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Tarring-Cargo Fune Aberdeen, Maryland	eral Hom	e <sub>33</sub> P <sub>9</sub> A.	
	Dharisian		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line.	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
7	Physician /Medical		timediate Cause (Final disease or condition resulting in death)  a. Consession Neart Failu  Due to (or as a consequence of):	re		5years
4	Examiner	je.	Tatana Pinana (	fibros	īs	Sugar
	and I-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):			20 years
68760,	ificate be executed g physician and as the burial-transit	edicai E	d. Sleep aprica			10 years
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date Mon	e of delivery tth Day Year
rds, P	uires that n signed b	d by Pr	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ibute to the cause of death?  3 Probably 4 Unknown
Vital Records,	The law requirate has been spage 2 should	Completed		24a. Was auto perfo 1 \( \text{Yes} \)	psy p prmed? d	Vere autopsy findings available rior to completion of cause of eath?  Yes 2 No
Vita	ician: Th certificate rector, pag	Be	examiner?	ath (Check only o	one)	
of	Phys r this ral dir	-: To			dence 6 Othe	
lon	ding th. : After	ition	27. Manner of Death  1			
Division of	of or Atternation of a street or Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or To		er or Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	e, and due to the urred at the time,	cause(s) and mar date and place, a	nner as stated. and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
			D 36715		March 2	13,2006
	+		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sherif H. OSMAN, M.D. 520 UpperChesapeak	e Dr.	#211 B	e/A. (M)
	Sta Registr		MAR 3 0 2006 Security Signature (Mark 3 0 2006)			,

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Year Chester M. Leishear 17, March 2006 11:36 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville
If Under 1 Year | If Under 24 Hrs. Shady Grove Adventist Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**™**M 2□F Months Hours Director 214-34-2473 Oct. 16, 1914 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ehov the Madical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with and Mental Hygiene.

Is marked other then "natural", or iteme 23a or it 12500 Prices Distillery Road Completed by Funeral 20872 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer 8th Farming other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ Eli Molesworth Leishear Goldie Vernon Dwyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Self - by pre arrangement 12500 Prices Distillery Road, of Disposition (Name of Dan.ascus, Maryland 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages . 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Depertment of Important: If eny injury or once: Mt. View Cemetery 4 □ Donation 5 □ Other (Specify) 3/20/06 Damascus, Maryland 21. Signalure of Pyneral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ocardia arcti disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cronc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cete has been signification hemic 22 1 ☐ Yes 2X No 3 Probably 4 □Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certifice funeral director, p Be 25. Was case referred to cal examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 1 ☐ Yes 2 ☐ No 1 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural Injury within 24 hours after death.

To the Funerel Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 10054068 30. Name and address of person who completed cause of reath (Item 23a) (Type, Print) Shady Grave Hospital - Rochville - MD Leebelle , MD HERTIG 32. Restrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 0 2006 Registrar

Jonathan Z. Lyles Amend item#28d; pen E, 834, 47076 III Ensure All Copies Are Legible. 06 - 1922State of Maryland / Department of Health and Mental Hygiene AKG For State Registrat Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician March 18, 2006 JONATHAN ZACHARIAS LYLES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Center If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1(XM 2□ F Yrs. 24 Director 218-04-7733 FEB. 20, 1982 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Heelth and Mental Hyglene. important: if item 27 is marked other then \*natural', or items 23a or 28s-f show any injury or other traumatic event, its Medical Examinar must be notified at once. PRINCE GEORGE'S OXON HILL Directo MARYLAND 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 20745 U.S.A. 6259 OXON HILL RD., APT. B-3 Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes ZY□XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 Yes XXNo Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALES ASSOCIATE FAMILIO ASSOC. 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 BETTY ANN COOPER LARRY ERNEST LYLES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 401 NANJEMOY DRIVE, LA PLATA, MD 20646 BETTY LYLES-MOTHER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) XXBurial 2 Cremation 3 Removal from State 3-28-06 MEMORIAL GDNS WALDORF, MARYLAND TRINITY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 22. Name and Address of Facility RAYMOND FUNÉRAL SERVICE, P.A. LA PLATA, MARYLAND 20646
Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause or each line.

**Physician** /Medical Examiner

or Attending Physicien: The lew requires that the death certificate be executed for use as the burial-transit cete hes been sig , pege 2 should b

Box 68760,

P.0.

Records,

Division of Vital

Hospital

Physician/Medical Examiner þ Be Completed 27. Manner of Death

Certification: To this s effer de-ral Director: Ate to the fr

Within 24 hours enter To the Funeral Directory

Medical

3 State Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 15√Yes 2 No

1 Natural

2 Accident

4 Homicide

(Check only one)

30. Name and address

29b. Signature and title of certifier

3 Suicide

29a. Certifier

Immediate Cause (Final disease or condition resulting in death)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

118/06

GUNSMOT

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death

9 Unknown

4☐Pregnant at time of death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) NEAR SIDENALK GRASSY AREA

28b Time of

WOUNDS

28c. Injury at Work? 1 Yes

3 ☐Ectopic pregnancy

5 Other (specify)

28d Describe how injury occurred Subject was shot SCCAC t 1 281. Location (Street and Number or Rural Route Number City or Town, State) RUAS

24a. Was an autopsy performed?

1) Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

(2) OF CHEST AND FINGER

ZEKIAMRUN 615 LA PLATA, mo 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

2 🗌 No

29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) March 19, 2006

23d. Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of

2 No

Month

23e. Did tobacco use contribute to the cause of death?

death?

3. Time of Death

1 ☐ Yes 2 ☑ No

Approximate Interval Between Onset and Death

Year

8:48 A

d cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland no

RIAPLE

31. Date filed (Month Day,

person who com

32. Registrar's Signature

			1 ≈ For State Registrar	State of Ma	arylan		artment of H			iene	6	005	6
	100		1. Decedent's Name (First, Middle, La	ast)					2. Date of Deat	h		3. Time of [	Death
	Physici		Courtney E	stelle	Laq	ana			March	12, 200	)6	9:20	рм
	/Medic		4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of Death		4c. County			
7	ia .		Calvert Memoria	l Hospital			Prince	Frederi	ck	ck Calvert			
	Funeral		5. Social Security Number 6.	Sex 7. Ag	Θ (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Yearl	9. Birthp	lace (State or	Foreign
No.	Director		212-54-5950	1□M 2 <b>X</b> F	80	Yrs.	MOMINIS Days	riours with.	Jan. 24	, 1926	Wash	ïńgton	, DC
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	nation				1	0d. Inside City	ı Limite
	ehor	5	MD Calver	.+		North 1					'	1 X Yes	
	Ne M	Director	10e. Street and Number			VOL CII				0- 01	40		
	with	급					10f. Zip Code 2071	1	'	0g. Citizen of \ U.S.		itry ?	
	eath	Funeral	3947 5th Stree	12. Was Decedent	Ever in II	S 13 '			pacify Yas or No.			an Indian,	
	Her d	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💢 I		.5.	Was Decedent of Hi If Yes, specify Cubar	n, Mexican, Puerti	o Rican, etc.)		k, White,		
336	Jr. of	b	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 ☑ No	Specify:		Specify	whi	Lte	
ŏ	2 hou	Completed	15. Decedent's E			16a. Dece	dent's Usual Occupa	ition		16b. Kind of B	ısıness/In	dustry	
215	hin 7	ple	(Specify only highest gi	rade completed) College (1-4or 5	i+)	life.	kind of work done d DO NOT use retired,	luring most of wor. )	king				
2	d wit	5	12			ho	memaker			ЙO	n hoi	me	
nd	be filed within 72 hours after death with the Maryland nat Hygiene.  d other then "naturel", or items 23e or 28e-f ehow event, I're Micdical Examinational Campillad at	Be (	17. Father's Name (First, Middle, Las	st)					ne (First, Middle, I				
<u>la</u>	should bund Ment	2	August Mas	ke				Beatr	ice l	McNamar	e 		
Maryland 21215-0036	and and is mu		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number	City or Town,	State, Zip	Code)	
	and ealth m 27		Charles Lagana, s	on	1		Bayside 1	Rd., Che				20732	
altimore,	Pages 1 nent of H ant: If Ite		20a. Method of Disposition 1∑ Burial 2 ☐ Cremation 3 [	Removal from State	, c	emetery, crei	sition (Name of matory or other place			20c. Location -	City or To	own, State	
<u>=</u>	ment tant:	L.	4 Donation 5 Other (Spec	ity)	So.	. Memoi	rial Garde	ens  03-1	6–2006 I	Dunkirk	, MD		
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23e or 28e-1 show eny injury or other traumatic event, the Medical Examinating to notified at ODGs.		21. Signature of Funeral Service Lice	ensee	1		2. Name and Addres	19.30		85507	372		
	40 = 0		Duya	// fee	oal		ausch Fun				, MD		
			23a. Part1. Enter the disease, or conshock, or hear fail re. List only	y one cause in each li	ne.	n. Do not ent	er the mode of dying	, such as cardiac	or respiratory arre	est,		Approximate Interval Betw Onset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	- Acu	te r	2400	ardial	Infa	ection			0.1001 4.10 5	
	/Medical Examiner		Testing in doaling	to (or as	a consequ	uence of	. ^ ^	7					
		er	Sequentially list conditions,	b. Due to (or as	200	7-7-	Hate	DY D	18006		_		
	ted	듣	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (01 a3	a consequ	usilos 01). •		•					
	xecu and al-tra	Examin	that initiated events resulting in death) Last	c. Due to (or as	a consequ	uence of):		-					
8760	cate be executed physician and the burial-transit												
289	ficate physics the	edical		0.									
ŏ	the death certific y the attending p iched for use as	N	IF FEMALE: 23b. Was decedent pregnapt	23c. If yes, outcome						23d. Da	te of delive	ery	
ň	d for	Cla	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregnancy Other (specify)			Мо	nth	Day Y	ear
o.	that the de led by the a detached t	Physician/M	9 Unknown	9□ Unknown									
ď.	The law requires that te has been signed b page 2 should be deta	by P	Part II. Other significant conditions	contributing to death b	ut not resi	ulting in the u	nderlying cause give	n in Part I.	23e. Did tob	acco use cont	ribute to th	ne cause of de	ath?
Records,	w require been sig should b								1 □ Y€	s 2 No	3 🗌 Prob	ably 4 🔐	<del>nkn</del> own
ပ္ထ	aw re	Completed							24a. Was a		Nere auto	psy findings a	vailable
ř	The lav	E							autops perform	ned?	brior to coi death? I □ Yes	mpletion of ca	use or
		Bec	25. Was case referred to medical					26. Place of Dea	th (Check only on		L 103	2010	
>	ysici is ca direc	To E	examuter? 1 1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2 m	ER/Outpatier	t 3 DOA Othe	r	ome 5 🗆 Reside		er (Specit	y)	
T of	Jing Ph J. After th funeral		27. Manual of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry v Year)	28b. Time of	28c. Injury Work	at 2	28d. Describe ho	w injury occur	ed		
<u> </u>	tendir leath. tor: At the fu	atle	2 Accident investigation	on		,		res 2 □No					
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of Inju- building, etc			eet, factory, office		28f. Location (St. City or Town		er or Rura	l Route Numb	)e <i>r</i> ,
	To the Hospital or Attending Physician: whin's 24 hours after death as a first death first certification to the Funeral Director. After this certification plately filled in by the funeral director.												
	Hosp 14 hot Fune Tely fill	edical	(Check only 2 - Medical Exa	hysician: To the best	examinal	wledge, death	n occurred at the tim vestigation, in my op	e, date and place inion, death occu-	, and due to the ca	ause(s) and ma ate and place,	nner as si and due to	tated. the cause(s)	
	thin 2 the mplet	Med	one) 29b. Signature and title of certifier	and manner sta	ited.		29c. License			9d. Date signe			
	F ≥ F S €		Signature and title of certifier	1 / 1 / 1	1		Too Doonse	7-7/		Date signe	_ (monu),	Lay, real)	
	772		Fay ()	(Vey)	17			Say		21171	200	76	
	4	<	30. Name and address of person who	completed cause of d	eath (Rec	(Type,	Print)	10	L. A .	1	M	72	065
	Sta	to	31. Date filed (Month, Day, Year)	32. Registr	s Signa	ture	SACOX	Kd,	Juny J	Jours			
*			MAD 1	1 2hns	60.0	H	diast a		'				

				artment of Health and Men tificate of Death		ene 2006	10057
			Decedent's Name (First, Middle, Last)	2. [	Date of Death	1	3. Time of Death
	Physici /Medio		Lawrence Gerald Lipscomb		arch 11	, 2006 Year	5:35 P. M
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Calvert Memorial Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Prince Frederick  If Under 1 Year   If Under 24 Hrs.   8.		Calvert	
	Funeral Director		219–34–7929  Usual Residence of Decedent	Months Days Hours Min. (	Date of Birth (Month, Day, ept. 7,	Year) Co	hplace (State or Foreign untry) hington, DC
	be filed within 72 hours after death with the Maryland lat Hyglene. d other than "nature!", or items 23s or 28e-f show event, the Medical Exerciser must be notified at	2	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits 1 ☐ Yes 2X No
	the M	Director	Maryland Calvert St. Leona	ard 10f. Zip Code	10	g. Citizen of What Co	
	3a or	i Di	7500 Russell Court	20685		Jnited Sta	•
	death	Funerai		Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica		14. Race - Ame	rican Indian,
36	be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or items 23s or 28e-f show event, the Medical Exaction must be notified at	by Fu	1 Never Married Married 1 XYes 2 No 1956-	Yes 🎾 No Specify:	an, etc.)	Specify:	
9	2 hour	ed b	15. Decedent's Education 16a. Deced	lent's Usual Occupation	1:	6b. Kind of Business/	ite
212	thin 72 Br. na Me.til	piet	(Specify only highest grade completed) (Give	kind of work done during most of working OO NOT use retired)		00, 11110 01 00011000	doi.y
7	filed withi Hygiene. sthar than	Completed	12 Sheet	Metal Worker		Self Empl	oyed
Maryland 21215-0036	should be fill nd Mental H marked oth	To Be	17. Father's Name (First, Middle, Last)  Lawrence Bailey Lipscomb	18. Mother's Name (Fir Lillian Ma			
Mary	12 ha	Y 1		g Address (Street and Number or Rural Ro. Russell Court, St. I			
ē,	s 1 and 3 f Health item 27 other tr		20a. Method of Disposition 20b. Place of Disposition			Oc. Location - City or	
<u> </u>	Pages nent of I ant: If its ary or o		L Dunai 2 A Cremation 3 Linemoval from State	can Crematory 3/13/2	2006 A	lexandria	, Virginia
Baltimore,	permit. Page Department of Importent: If any injury or once.	20		Name and Address of Facility Rauso 05 Broomes Island Road,			
k	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	r the mode of dying, such as cardiac or res	spiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a				1 clay
	Examiner		Sequentially list conditions, b. PNEUMONII	Α			1 day
Ī	ted nsit	nine	if any, leading to immediate Due to (or as a consequence of):	NIC			1 15
Ď,	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last  c. CAVCER LU  Due to (or as a consequence of):	NG			1 maris
08/PN	certificate b Iding physic	edical	d				
XOD	leath certific attending p	M/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Catania		23d. Date of deli	very
_	the death y the atten ached for u	Physician/Me		Ectopic pregnancy Other (specify)		Month	Day Year
as, r	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
records,	s been shou	lete			24a. Was an	24b. Were au	topsy findings available
_	eicien: The law r s certificate has be lirector, page 2 sh	Completed			autopsy performe	prior to death?	ompletion of cause of 2 No
VII	yaicien: is certific director,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death Ch			
0	this b	n: To	27. Manner Death 28a. Date of Injury 28b. Time of			ce 6 Other (Spec injury occurred	ify)
lon	Attending or death.	atio	2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	el or Atto s efter de l Directo d in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28f. L	Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospitel or Attending Physicien: whithin 24 hours steff edain; setfulcation. To the Funerel Director: After this certific completely filled in by the funeral director,	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invariant manner stated.	occurred at the time, date and place, and destigation, in my opinion, death occurred at	due to the cau t the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Month	, Day, Year)
				D36969	=	3/12/06	
1,	5+1		30. Name and address of person who completed cause of death (Item 23a) (Type, F SCARIA MATHEW WD. PO BOX 1	789, LUSBY 1	MD 2	20657	
	Star Registra		31. Date filed (Month, Day, Year)  MAR 1 4 2006	Sparke			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 March 16, 1:15 P **Physician** Litzberg S. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring 15107 Interlachen Drive, Apt. 920 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) Min. Min. May 5, 191 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 M 2 F Illinois 92 216-44-9998 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ir than "natural", or items 23s or 28s-1 show tre Medical Examinat must be notified at 1 ☐ Yes 2X No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20906 USA 15107 Interlachen Drive, Apt. 920 Funeral death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ☐Yes 21☐No f Yes, Give 1 Never Married 2 Marned hours after Specify: White 1 ☐ Yes X☐ No Specify: Maryland 21215-0036 þ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Secretary Ith and Mental Hygie 27 is marked other r traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Manilla Peterson Pages 1 and 2 should be Kuno Gustav Seidel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) And of Health and Analysis if item 27 is monthly of other tr 19a. Informant's Name/Relationship (Type, Print) 13580 West Oak Court, Bloomington, IL 61704 William E. Peterson/Nephew Date 16, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 20c. Location - City or Town, State 20a. Method of Disposition March 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria, Virginia permit. Page Department of Important: If eny injury or once. 2006 4 ☐Donation 5 ☐ Other (Specify) Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature Fundral Service License 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 Week **Physician** Pneumonia resulting in death) /Medical Due to (or as a consequence of): Examiner Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, tha attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? detached for 4 Pregnant at time of death 5 Other (specify) Yes 2 No P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Division of Vital Records, Hypertension, Atrial Fibrillation 99 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Yes 2 No 2 X No 1 ☐ Yes cartificate To the Hospital or Attanding Physician: within 24 hours aftar death.

To the Funeral Director: After this cartific completely filled in by the funeral director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? 5 Pending **XIX**Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Contifying Physician: To the best of my knowledge death accurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 16, 2006 D23958 ress of person who completed cause of death (Hem 23a) (Type. Print)
Feldman, M.D. 3305 N. Leisure World Blvd, Silver Spring, MD 20906 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 7 2006 Registrar

			For State Registrar	State of	Marylaı		artment rtificate			and M	lental Hy	giene	06	10059
	· #.		1. Decedent's Name (First, Middle, I	.ast)				-			2. Date of De	ath		3. Time of Death
	Physic /Medi		Prudence Louis	se Lane							Month March	Day 15	2006	11:25 P <sup>M</sup>
	Examir		4a. Facility Name (If not institution, g	ive street and num	ber)		4b. City, T	own, or	Location o	of Death	1101011		ounty of Death	
*			St. Mary's Nursi	ng Cente	r		Leon	ardi	town			St	. Marv	¹ c
h	Funeral		Social Security Number     6.	Sex 7		last birthday)	If Under 1 Months	Year Days	If Under :	24 Hrs. Min,	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		215-46-4269	1□M 2X□F	93	Yrs.	Months	Days	110013		May 20		~	souri_
	pue ≱		Usuel Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo	cation							40.14.00.11.11
	Aaryl sho	5												10d. Inside City Limits 1  Yes 2  No
	28a-	Director	Maryland St. Ma	ry's	St	. Mary'								21
	with a o	ō					10f. Zip (						n of What Cou	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Mudical Examiner must be notified at	Funeral	47339 South Sno	W Hill Ma 12. Was Deced				0686					ed Sta	
	fter d	Fun	1 Never Married 2 Married	Armed Ford	es?	7.3. IS. V	Yes, specif	y Cubar	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Ameri Black, White,	
38	urs at	by	3 X Widowed 4 Divorced	If Yes, Give Year or Dat		1	☐ Yes 2	X No	Specify:			Sp	рес <i>ify:</i> Wh:	ite
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פ	be file tal Hyg d othe	Bec	17. Father's Name (First, Middle, Las	st)						r's Name	(First, Middle,			<b>Z</b>
<u>a</u>	Alenta Alenta rked tice	TOE	Byron Bliss						Jane	e Ma:	rtin			
Maryland	should and Men smarks sumatic		19a. Informant's Name/Relationship			19b. Mailin	g Address (	Street a	nd Numbe	r or Rura	I Route Numbe	r, City or To	own, State, Zig	o Code)
_	and 2 alth a 27 ly		Elisabeth L. Vir	nstein /I	)aught	er 142	Eigi	n Rd	. Eas	st Pa	alatka	F1. 3	2131	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, Ita Madical Examiner must be notified at once.		20a. Method of Disposition		20b. F	Place of Dispos	sition (Name	of			ate		tion - City or To	own, State
Ĕ	Page nent in int: If		1 N Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		ale	inity C	-			3/29	5/2006	Sain	t Mary!	e City
att	permit. Departn Imports any inju		21. Signature of Fun at Service Lice	ens e MC	1206				of Facility	Bri	nsfield	Fune	ral Hom	a PA
m	90 5 6	10	July me	Kyle	S. Sin	nons 2	2955 H	Io11	vwood	l Rd	Leona	rdtown	n Marvl	and 20650
			23a. Pag1. Enter the disease, or cor shock, or heart failure. List only	nolications that cau	ised the deat	h. Do not ente	r the mode	of dying	, such as c	cardiac o	r respiratory ar	rest,	110191	Approximate
	Physician	3 19	Immediate Cause (Final	y one cause on eac		, Alzi	eres	,	Dem	ent	٧.			Interval Between Onset and Death
99	/Medical		disease or condition resulting in death)	a Due to (or	as a consec	neuce of):							-	
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9	ng pt	Med	IF EEMALE.					1						
Rox	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna		Ectopic preg	nanau	•			23d	. Date of delive	ery
	ed fo	SICI	in the past 12 months?		it at lime of d		Other (spec						Month	Day Year
J.	at the de I by the stached	Physic	9 Unknown											
Ś	requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	٥	Part II. Other significant conditions	contributing to deal	th but not res	ulting in the un-	derlying cau	se giver	in Part I.		23e. Did to	bacco use	contribute Io II	ne cause of death?
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ပ္	e law r has be je 2 sh	be	Decuph. Osteolo	wee							24a. Was a		4b. Were auto	psy findings available
	The ate ha	E O	Osteplo	rend							autop:	med?	death?	mpletion of cause of
VITAI	<b>是</b> 差 2	Bec	25. Was case referred to medical examiner?		-				26. Place	af Death	1 ☐ Yes (Check only or	-	1 🗀 105	2 140
0 0	S UP	2	1 Yes 25 No	Hospital: 1   Inp	atient 2 🗌	ER/Outpatient	3□ DOA	Other			e 5 Resid		Other (Specifi	v)
	ding Ph th. After th funeral	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of (Month.	njury Day Year)	28b. Time of Injury	28c	Injury a			8d. Describe h			.,
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UNISION	To the Hospital or Attenswithin 24 hours after death To the Funeral Director: completely filled in by the	Certificati	3 Suicide 6 Could not be determined	280. Place of	Injury - At ho	ome, farm, stre	et, factory, o	ffice		2	8f. Location (S. City or Town	treet and Ni	umber or Rura	l Route Number,
ב	To the Hospital or At within 24 hours after or To the Funerel Directompletely filled in by	Se				′′					City or You	i, State)		
	t hour	ca	29a. Certifier 1 Certifying Pl	nysician: To the be	st of my kno	wledge, death	occurred at	he time	, date and	place, a	nd due to the c	ause(s) and	manner as st	ated.
	the hin 24 the F	ledic		miner: On the basi and manner	stated.	non and/or mve	stigation, in	my opir	nion, death	occurre	d at the time, d	ate and pla	ce, and due to	the cause(s)
	5 tig 6	Σ	29b. Signature and title of certifier		<b>N</b>			icense i			2	9d. Date si	gned (Month,	Day, Year)
			, h	Jun			00	006	211	>		3/18	101	
			30. Name and address of person who	completed cause	of death Item	23a) (Type, P						+	1	
			Juresh	1. ras	u	22650	Ceda	r La	ine C	t. L	eonardt	own,	Maryla	nd 20650
	Stat		31. Date filed (MonWAR 200 2	006 32 legi	istrar's Signal	lure #								
	Registra			- Cape	Mary A	70 4								

Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 13, March 2006 1430 McCoy Lee /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Prince Georges Hospital Center Cheverly II Under 1 Year II Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) - Funeral Months 1**∑**M 2□F Yrs. Director Oct.15, 1948 247-86-0708 Usual Residence of Deceden Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f ehow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f ehove the Medical Examiner must be notified at 1⊠Yes 2□No Funeral Director Capital Heights Md. PG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States Court 20743 1007 Huntsworth Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Metro 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Israel Louise Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Huntsworth Court Terita A. McCoy/daughter r Capital Heights, Md.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20743 20c. Location - City or Town, Slate 20a. Method of Disposition permit. Pages
Department of I
Important: If its
any injury or of 1 Surial 2 Cremation 3 Removal from State |Harmony Mem. Park | 3/21/06 Landover, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md.20746 Hart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastatic Disease resulling in death) /Medical Due to (or as a consequence of): Examiner Aortic Sarcoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consectioned of) Examiner the attending physicien and hed for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Dunknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2[X No 1 Yes 2 X No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: After 5 Pending 1 XNatural s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) To the Hospitel a within 24 hours aff To the Funeral Di pellij t Scentifying Physician: To the best of my knowledge, doubt occurred at the limit date and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 33th Cartifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D27577 March 14, 2006

State Registrar

31. Date filed (Month, Day, Year) MAR 1 7 2006



who completed cause of death (Item 23a) (Type, Print)

Cheverly, Md.

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month -ERMAN Kinne 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RALTIMORE
TYPE If Under 24 Hrs. Medical enter Saltimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) March 20, 1 **Funeral** Months Days 15 M 2 ☐ F Hours 426-03-8181 Director 85 1920 Arkansas March Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits fleme 23a or 28a-f ehow rthen "naturel", or fleme 23a or 28a-f ehov tre Medical Examinar must be notified at 1 Yes 2 □ No Directo Wash.D.C. None Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 N. Capitol St 20011 Pages 1 and 2 should be filed within 72 hours after death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Gyes 2 No 1956-If Yes, Give Year or Dates: 1962 1 → Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Military Soldier other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Department of Health and Mental important: If Item 27 is marked o eny injury or other traumatic eve once. ၉ George McKinney <u>Maudie McRae</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2413 Vence Ct., Gautier, MS <u>Rebecca Carlisle (Niece)</u> 39553 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Biloxi Nat. Cemetery 3 3/20/06 Biloxi, MS 21. Signature of Funeral Service Licensee Murphy Funeral Home 4510 Wilson Blvd.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUBARACHNOLD HEMORRHAGE
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical ettending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate hes t 24a. Was an autopsy performed? Yes 2 No 1 Yes or Attending Physicien: director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA nours after death.
nerel Director: After this
filled in by the funeral di 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certifier 29c. License number UMNS ID 16775 29d. Date signed (Month, Day, Year) MD who completed cause of death (Item 23a) (Type, Print) EYVAZZADEH DANIEL 10 N. Greene Street Boltmine MD 21201 31. Date filed (Month, Day, Year) State Registrar

Matthews

For Stete Registrar

**Physician** 

**Funeral** Director

/Medical

1. Decedent's Name (First, Middle, L

4a. Facility Name (If not institution, g

ohn

Type or Print in Black Inc	delible Ink. Ensure A	II Copies Are Leg	ible.
State of Maryland / Depa Cer	rtment of Health and I tificate of Death	Mental Hygiene	06 10063
usi)	US	2. Date of Death Month Day March 19 200	Year 3. Time of Death 7:30 A
ive street and number) d Rehabilitation Center	4b. City, Town, of Location of Death		ty of Death
Sex 7. Age (In yrs. last birthday). 1⊠ M 2□ F 87 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 10/10/1918	Birthplace (State or Foreign Country)     MD
10c. City, Town or Lo	cation		10d. Inside City Limits
Annes Centrevi	11e	1.0 00	1 ☐ Yes 2 🔀 No

Examiner Berlin Nursing on 5. Social Security Number 214-03-7577 Usual Residence of Decedent 10a. State 10b. County Directo Queen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 314 Claiborne Fields Dr. 21617 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Accounting Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lacy D. Budd John W. Matthews, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 314 Claiborne Fields Dr., Centreville, MD 21617 Myrtle S. Matthews 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Cape Henlopen Crem. Frankford, DE 3/20/2006 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 21. Signature of Funeral Service Licensee-236. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, atherosclerotic heart disease Immediate Cause (Final disease or condition resulting in death) years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Completed by Physician/Medical

23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Year 4☐ Pregnant at time of death 5 Other (specify) 9□ Unknown 23e. Did tobacco use contribute to the cause of death?

C1-0006795

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

obstructive pulmonary 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

3-19-06

24a. Was an autopsy performed 2 10 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

Approximate Interval Between Onset and Death

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c, Injury at Work? 1 Natural

5 Pending 1 ☐ Yes 2 ☐ No investigation М 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

29a. Certifier 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KRISTINE GRIFFIN, MO 1209 COASTAL HIGHWAY FENNICK ISLAND, DE 19944

31. Date filed (Month, Day, Year) State MAR 2 0 2006 Registrar

IF FEMALE:

Be

Certification:

Medical

9 Unknown

32 Registrar's Signature

			For State Registrar	State of Ma	ryland		rtment of H		and Me		giene Reg. No.	6	0064
			1. Decedent's Name (First, Middle, L						2	Date of De	ath Day	Year	3. Time of Death
	Physici /Medic		1/2V/	Marcin						1200		06	8:1010 W
	Examin		4a. Facility Name (If not institution, g				4b. City, Town, o	or Location o	of Death		4c. Coun	ty of Death	
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п	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 7. A/ge 1 □ M 2/SIF 96	(In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under :	Min.	Date of Bird (Month, Da	y, Year)	9. Birth	place (State or Foreign
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	yland		10a. State 10b. County		10c. City, 7	Fown or Lo	cation					1	I Od. Inside City Limits
	Mar a-1 st	ctor	Maryland		Co1um	bia							1 ☐ Yes 2 ဩ No
	or 28	Director	10e. Street and Number				10f. Zip Code	-			10g. Citizen o	f What Cour	ntry?
	23a	ra	5239 Hesperus Dri				21044				United		-
	ltams	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of H Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Specif i, Puerto Ric	y Yes or No an, etc.)		ace - Americ ack, White,	
36	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-1 show Ira Madical Examirer must be notilled at	by F	1 ☐ Never Married 2 ☐ Married 3 ② Widowed 4 ☐ Divorced	1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates:	0	1	☐ Yes 2 🖾 No	Specify:			Spec	ity: Whi	ite
21215-0036	2 hou		15. Decedent's	Education	1		ent's Usual Occur				16b. Kind of	Business/In	dustry
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nd	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. Is marked other than "natural", or itams 23e or 28e-1 show aumatic event. It a Madical Examilier arrust ba notified at	Be (	17. Father's Name (First, Middle, Las	st)				18. Mothe	er's Name (F	irst, Middle,	Maiden Suma	ime)	
Maryland	should be ind Mental marked o	ပ	Peter Sebol					-	Hrivr				
lar	ges 1 and 2 should t of Health and Men If item 27 is marke or other treumetic		19a. Informant's Name/Relationship		1.3		g Address (Street						Code)
	1 and lealth am 27 thar t		Raymond Marcin / 20a. Method of Disposition	Son	_		Hesperus	Dr. (	Columb Date		D 21044 20c. Location		own State
Jor	ages nt of I		1 ☐ Burial 2 🖾 Cremation 3		cem	etery, crem	atory or other place Cremato		3/17/2				
Baltimore,	artme artme ortani injury		* 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic	* .	rica		Name and Addre	-					Maryland
Ba	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		> Bully JAS	*		1	621 Opos	sumtov	wn Pik	te, Fr	ederick	, MD	21702
I,			23a. Part1. Enter the disease, or co shock, or heart failure. List in	inplications that caused to y one cause on each line	he death. I	Do not ente	er the mode of dyla	ng, such as	cardiac or re	espiratory a	rest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a			Phem	vino	_				Zvecks
	/Medical Examiner		resulting th death)	Due to (or as a	consequer	nce of):							
		i i	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	nce of):			-					
	uted J ansit	Examiner	cause. Enter Underlying Cause Clasease or injury			·							
Ć,	exection and and ital-tra	Exa	resulting in death) Last	C. Due to (or as a	consequer	nce of):	<del></del>						
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai		d									
9	n certifica anding ph use as th	Med	IF FEMALE:				-						7
Вох	ath certif attending for use a	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o 1 ☐ Live birth 2		eath 3 🗌	Ectopic pregnancy	y			1	ate of delive	ery Day Year
0.	the dea y the al	sici	1 Yes 2 No	4∏Pregnant at t 9∏Unknown	ime of deat	h 5□	Other (specify) _					Юпит	Day
۵.	± > ∞	by Physician/Me	Part II. Other significant conditions	contributing to death but	not resultin	na in the un	deriving cause gry	en in Part I		23e. Did to	obacco use co	ntribute to t	ne cause of death?
Records,	se un eq		·	, and the second		•	,			1 🗆 1	res 2 No	3 🗆 Prob	pably 4 Unknown
Sor		Completed			_					24a. Was	an 24h	Wara auto	psy findings available
Re	e la has	mo								autop perfo	rmed?/	prior to co death?	mpletion of cause of
Vital		e Cc	25. Was case referred to medical					26 Place	of Death (	1 ☐ Yes Check only o	2 No	1 🗆 Yes	2LIN0
>	8 5	0 B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2□ER	VOutpatient	3□ DOA Cth				dence 6 🗆 O	ther (Specif	(v)
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io	Attending r death. actor: Afte	atio	1 Natural 5 Pending 2 Accident investigation	on	. 54.7	n qui y		Yes 2 1	No				
Division	or Atterde	Certification:	3 Suicide 6 Could not determine		y - At home (Specify)	e, farm, stre	et, factory, office		28f	Location (S City or Tov		ber or Rura	Il Route Number,
	oital c urs af ral Di												
	To tha Hospital or Attend within 24 hours after death To the Funaral Diractor: completely filled in by the	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	hysician: To the best of the basis of the basis of and manner state	examination	dge, death and/or inv	occurred at the tire estigation, in my o	me, date and opinion, deat	d place, and th occurred	I due to the at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
	To tha within 2 To the complet	Me	29b. Signature and title of certifier	Duil On	2		29c. Licens	e number			29d. Date sign	ed (Month.	Day, Year)
				on you	WO		100	00590	943		March	216	,200Ce.
	10		30. Name and address of person who	5 152 0	ath (Item 23	3a) (Type, f		ء حس	tmine	12 - M	71	150	
	Sta	te	31. Date filed (Month, Day, Year)	295 ) The	's Signatur	. )	VIPE 301	V >	Jenthi)	-γ  ·	ات دساد	17/	
	Registr	ar	MAR 2 0	2006 Been	u D	Ge	cule						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month LINDA SUE 7:03 PM M MCCLEARY 3 14 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F 59 219-46-1336 Yrs Director Maryland Nov. 10,1946 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28e-1 show the Madical Examiner must be notified at 1 ☐ Yes 2√ No Director Montgomery Maryland Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12203 Braxfield Ct. Apt. 12 20852 death United States "natural", or itame 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7;
Depertment of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other freumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Anna Mary Skipper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 473 Cedar Glenn Close, Neelysford, VA 22958 Kim Cavenee / Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet 3/20/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Opossumtown Oike, Frederic, MD 21702 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracrania) hemmushage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of). Box 68760, Completed by Physician/Medical the th use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed) 1 ☐ Yes 2 ☐ No 1 Yes 2,25No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2万No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA tor: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. and little of certifier 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) D0063498 2006 dress of person who completed cause of death (Item 23a) (Type, Print) Dr. Lalshvinder Wadhwa, 400 West Seventh St., Frederick, MD 21701

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 0 2006

		-	For State Registrar	State of Ma		artment of H		l Mental Hygi	ene 3. No. 0 0 (	0066
	A 2	<b>36</b>	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	3. Time of Death
	Physicia /Medic	_	Christine	Vio	ctoria	Manas	5	March 1		
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	r Location of De	ath	4c. County of	
33			Tate Chesapeake Ho			Linthic If Under 1 Year		rc   0 0 (0		Arundel
-	Funeral		5. Social Security Number 6. Sex	14 OFR E	(In yrs. last birthday	Months Days	Hours M	in. (Month, Day,	Year)	Birthplace (State or Foreign Country)
1	Director		133–09–7070 Usual Residence of Decedent	11	37 Yrs.			Nov 15,	1918	New York
	ow ow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Many -f sh fied	to	MD Anne Aru	ndel		Harwood				1 □Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	nat Country?
	23a c	a D	404 Richardson Cou	ırt			)776		USA	
	r dea	Funeral	T. Maritan Otatoo	<ol><li>Was Decedent E Armed Forces?</li></ol>	ver in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)		- American Indian, , White, etc.
36	or It	<b>by</b> F.	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give	0	1 ☐ Yes 2X No	Specify:		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "nature!", or iteme 23e or 28e-f show the Medical Exemples must be notified at	ed b	15. Decedent's Educ	Year or Dates:	16a. Dec	edent's Usual Occup	ation		6b. Kind of Bus	
7.	n "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)		life.	e kind of work done DO NOT use retired	during most of v d)	working		
212	d with	E	12	College (1-401 3-		omemaker			own h	ome
ğ	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's h	Name (First, Middle, M	aiden Sumame	)
<u>a</u>	Menta Menta arked	To E	Peter	Miano	1		Anna		Leifa	
Maryland	and and is m	o M	19a. Informant's Name/Relationship (Typ	e, Print)		•		Rural Route Number,		
e c	and fealth m 27 her ti		Bruce C. Manas, so	n				Harwood, N		/ b City or Town, State
0	ges 1 It of H If Ite or of		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		position (Name of ematory or other place				
Baltimore,	t. Pa		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License	•		rans Cemet 22. Name and Addre		-21-2006	'helten	nam, MD
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show emportant: if Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show emportant: if Item 23a or 28a-f show emportant in Item 23a or 28a-f show engine in Item 23a or 28a-f show engine in Item 33a or 23a-f show engine in Item 33a or 23a or 23a-f show engine in Item 33a or 23a o		William R	5 nor	- I	Rausch Fur	neral Ho	ome, P.A.,		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused e cause on each lin	the death. Do not e e.	nter the mode of dyir	ng, such as card	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
4.	Physician		Immediate Cause (Final disease or condition	Su	pranuel	en &	ci 15%			
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		/			
*	LAGIIIIICI	<u>.</u>	Sequentially list conditions, if any, leading to immediate		a consequence of):					
	bed nsit	ulne	cause. Enter Underlying Cause (Disease or injury	Due to (01 as t	consequence on,					
	axecur al-trai	xar	that initiated events c. resulting in death) Last	Due to (or as a	a consequence of):					
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	Physician/Medical Examine								
9	ifficati g phy as the	edlo								
Вох	leath certifica attending ph I for use as th	M/U	23b. Was decedent pregnant	Bc. If yes, outcome of		Ectopic pregnanc	v			of delivery th Day Year
O. B	deat he all	sicia	in the past 12 months? 1 □ Yes 2 🖾 No	4☐Pregnant at		Other (specify)	,		Mon	th Day Year
P.O	that the delegate the property of the property	Phy	9 Unknown					32a Did tab	acco uca contri	bute to the cause of death?
	8 5 9	by	Part II. Other significant conditions con	induting to death bi	at not resulting in the	underlying cause giv	ven in Part I.	1 ☐ Ye	_	3 Probably 4 Unknown
Vital Records,	w require been signature	Completed						24a. Was ar	245 14	Vere autopsy findings available
3ec	has by	ldm						<ul> <li>autopsy perform</li> </ul>	ned? p	rior to completion of cause of eath?
a	Da ale						00 81			☐ Yes 2☐ No
₹	Physicien: The this certificate har all director, page	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No H	ospital:	nt 2 ER/Outpati	ent 3□DOA Ott	200	Death <i>(Check only</i> one og Home 5 ☐ Reside		r (Specify) Hospice
of	Phys ar this eral di	7: To	27. Manner of Death	28a. Date of Injur (Month, Day		of 28c. Inju		28d. Describe ho		
Ö	Attending I r death. ector: After by the funer	at lo	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	<i>r Year)</i> Injury		Yes 2 □No			
Division of	or Attendated after deat	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, c. (Specify)	street, factory, office		28f. Location (Sti City or Town		er or Rural Route Number,
_	Hospitel 4 hours Funerel ely filled	edical Co	(Check only 2 Medical Exemin	er: On the basis of	examination and/or	ath occurred at the transvertigation, in my	me, date and pl opinion, death o	lace, and due to the ca occurred at the time, da	use(s) and mar ite and place, a	nner as stated. and due to the cause(s)
	To the I within 2. To the I complet	Med	29b. Signature and title of centaier	and manner sta	II.e.d.	29c. Licen	se number	29	d. Date signed	(Month, Day, Year)
)	To To		1/1/1	12/As		1	0711	1	March	/
7	1		30 Name and address of person who	moleted cause of d	eath (Item 23a) (Tun	e Print)	- 1/1	/ /	1000	10) (000
	lo		DIA COM Q	Dolun	OF CIA	5 Da	D Kto	DINP G	620	16,2006
10	St	ate	31 Date filed (Month, Day, Year)		at's Signature	. 1 .	U		,	1),1
	Regist	rar	MAR 1	3 2006▶ 🔏	Exerces St	MORNE				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year 12:44 PM **Physician** 2006 March 14, McMahon Pauline Theresa /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Manor Care Potomac Potomac If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) April 23,1916 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 21X F 485-09-1267 Towa 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County in than "natural", or itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☑ Yes 2 ☐ No Washington none Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20007 3825 Davis Place, N.W. death y Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 ™ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Flementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 ilth and Mental Hygir 27 Is marked other r traumatic event, othar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any injury or othar traumatic evant once Be Christina Starcevich Victor Tomljanovic 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Washington, DC 20007 3825 Davis Place, N.W. Rosemary C. McMahon/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 22, Beaver Catholic Cem. Granger, Iowa ' 4 ☐ Donation 5 ☐ Other (Specify) 2006 DeVol Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Locus 2222 Wisconsin Ave., N.W. Washington, DC 20007 Min 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) P.O. page 2 should be detached 9 Unknown 9 Unknown ğ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Division of Vital Records, 3 Probably 4 ☐Unknown 1 ☐ Yes 2 🖾 No Dementia, Hypertension, Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 X No 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Tes 2 No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No hours after death 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Pol March 14, 2006 D53615 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3411 Olandwood Court, Olney, Maryland 20832-1488 Aruna S. Nathan, MD. 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 20, 2006 6:35 **Physician** A M Mary Louise Morgan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's St. Mary's Nursing Center Leonardtown If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) January 31,1921 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🕱 F Maryland VIS 85 217-46-8366 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City. Town or Location 10a. State 10h County 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 🕅 No Leonardtown Director St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Itame 23a or USA Apt. 304 20650 22810 Dorsey Street, Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc filed within 72 hours after 1 Never Married 2 Marned 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White δ 3XXWidowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if item 27 is marked other the any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosetta Pilkerton James Ernest Wathen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6765 Boots Lane, La Plata, Maryland 20646 Barbara Ann Lewis/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 24, 2006 Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 21. Signature)of Funeral Service Liçensee Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic **Physician** /Medical Due to (or as a consequence of): ( (moll (ell +710) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Box 68760, physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) signed by the at d be detached for Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown COPD. HTN 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No of Vital or Attending Physician: director. 26. Place of Death | Check only one) Medical Certification: To Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After the funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Division 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D36206 anne 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (exter Hollywoof m) 20636. J. Bead Medical 31. Date filed (Month, Day, Year) . Registrar's Signature State MAR 2 1 2006 Registrar

_	_	Registrar					rtifica	te o	f Death			leg. No.	JUD	10003
alam)	1.	Decedent's Name (	(First, Middle, La	ist)						2.	Date of Dea Month	ith Day	Year	3. Time of Death
cian lical		Agnes	Rebe	cca	Marsh	a11					March	17,	2006	11:30 p.
iner	4a.	Facility Name (If n	ot institution, giv	ve street and nu	m <i>ber)</i>		4b. City	y, Town	, or Location of	Death		4c. C	ounty of Deat	th
	г	22427 Greenview Court Great Mil												
1	5.	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.								Date of Birth (Month, Day	Year)	9. Birt	hplace (State or Forei	
r		214-26-6	220	1 ∐ M 2∆JF	82	Yrs.		,			eb. 7,		4 Ma	ryland
	-	ual Residence of D												1
	10	a. State	10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Inside City Limit
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Directo	10	e. Street and Numb	per				10f. Zi	ip Code	Э			10g. Citize	on of What Co	ountry?
Funeral D		45083 B1	ackwe11	Court				2	20690			Un	ited S	tates
2	11	. Marital Status		12. Was Dec	edent Ever in L	J.S. 13.	Was Dece		of Hispanic Orig uban, Mexican,	in? (Specif	y Yes or No-		Race - Ame	ncan Indian,
į		1 Never Married	d 2 Married	Armed F	2 XNo			0.00		Puerto Ak	an, etc.)		Black, Whit	· _
3		3 XWidowed 4	□Divorced	If Yes, G Year or I	ive Dates:		1 🗌 Yes	21 <b>X</b> N	No Specify:			1 5	Specify: Bla	ack
e		1	5. Decedent's E	ducation		16a. Dece	dent's Usu	ual Occ	cupation			16b. Kini	d of Business	Industry
Completed	1		only highest gr			(Give	kind of wi DO NOT i	vork dor use reti	ne during most ired)	of working				
Ţ		Elementary/Second	sary (0-12)	College (	(1-4or 5+)		Home	ama k	zar				Own I	Ното
Š	17	. Father's Name (Fi	irst. Middle. Lasi	t)			TIOINE	Illar		s Name (F	First, Middle,	Maiden S		nome
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0	-	Saint El									llen W			T. O. I.)
	19	a. Informant's Nam							et and Number					
		Patricia		n / Dau					7iew Coι					
	20	a. Method of Dispo		70	20b.	Place of Dispo cemetery, crei	osition (Na matory or	ame of other p	olace)	Dat	9	20c. Loc	ation - City or	Town, State
		1 X Burial 2 ☐ 4 ☐ Donation 5			State	. Georg			1	-22-21	006	Va11	v Tee	Maryland
	2	I. Signature of Fune							dress of Facility	Brin	cfiold	Fun	orol U	ome, P.A.
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		Kyle S			M0120	0 /	4977	HOL	13757000	KOSO	· Leon	arata	own . MI	20650-02
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		shock, or heart	failure. List only	nplications that one cause on	caused the dea each line.		TO THE TANK OF THE PARTY OF		-					Approximate Interval Between
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/Medic Examin Funeral		4a. Facility Name (If not institution, give 45770 King Drive 5. Social Security Number 6. Se	9x 7. /		last birthday)	Lex	ingto	n Pa	rk 24 Hrs.	8. Date of Bir (Month, Da	St	• Mary 9. Birth	
Director	_	212-48-3391 15 Usual Residence of Decedent 10a. State 10b. County	_M 2X F	59	Yrs. y, Town or Lo	cation	Days	Hours	Min.	March 2			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or Items 23a or 28a-f show enty riqury or other traumatic event, I'm Madical Examinating relational the notified at ODGs.	by Funeral Director	45770 King Drive  11. Marital Status  1□ Never Married 2⊠ Married  3□ Widowed 4□ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date:	s? ∑No		Was Dece f Yes, spe 1 ☐ Yes				ecify Yes or No Rican, etc.)		USA  4. Race - Americal Black, White Specify: Wh	ncan Indian, e, etc.
thin 72 hou e. an "nature Madical E.	Completed I	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation		life. I	kind of wi	ork done d ise retired	lurina mos	t of works	ng		nd of Business/	
d be filed will hygien that other the count, the	Be	12 17. Father's Name (First, Middle, Last) Robert Irvin Mes	l chket		Во	okke	eper			(First, Middle	, Maiden	ail Ant Sumame)	iques
and 2 should laith and Mei 27 le mark ar traumatic	To	19a. Informant's Name/Relationship (7 Roy M. Maier / H	ype, Print)		4577	0 Ki	ng Di	and Numbe	er or Rura	u Route Numb	oer, City or Park	Town, State, 2	3
t. Pages 1 a tment of He rant: If Iten ijury or oth		20a Method of Disposition  1 🕅 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	)	te C	Place of Dispo cometery, cror arles Me	matory or moria	o <i>ther pl</i> ac l Gard	ens M	1ar 25		Leo	cation - City or nardtow	
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The law requires that the death certificate be executed itse has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ♣ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Fets t at time of d	al death 3[	□Ectopic p □ Other (s	pregnancy				2	23d. Date of dei Month	ivery Day Year
quires that t n signed by ald be deta	þ	Part II. Other significant conditions of	ontributing to deat	h but not res	sulting in the u	ndertying	cause giv	en in Part I	l.				the cause of death?
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To the Hospital or Attanding Physician: The I within 24 hours after death.  To the Funaral Director: After this certificate he completely filled in by the funeral director, page	ation: To Be	25. Was case referred to medical examiner?  1  Yes	1		ER/Outpatier 28b. Time o Injury		28c. Injur Wor	er: 4□N	ursing Ho	28d. Describe	sidence ( how injur		
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o the Hos vithin 24 ho o the Fun ompletely i	Medical	(Check only one)  29b. Signature and title of certifier	niner: On the basi and manner	s of examina	ation and/or in	vestigatio	n, in my o	pinion, dea	ath occur	red at the time	, date and	te signed (Mont	e to the cause(s)
F S F O		30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type,	Print)	2 50	486			3	3/23/01	0
Sta Regist	ate	Guydeep S. Chr 31. Date filed (Month Pay Year) MAR 24	2006 32. 19	istrar's Sign	24035 ature	Thr	e No	tch	Kd.	Holly	WOOD	d, MD	20636

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\display \( \frac{\pi}{2} \)	Funeral		5. Social Security Number 6. S	Sex 7	'. Age (In yrs.	last birthday)	If Unde	r 1 Year	If Under	24 Hrs.	8. Date of Birth	1,		hplace (State	or Foreign	
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486	p ,		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation		-					10d. Inside	City Limits	
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	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or itams 23a or 28a-f ehow event, the Madical Expira at must be incitified at	Funeral	11. Marital Status	12. Was Deced		J.S. 13.	Was Dece	dent of H	ispanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit			
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0	g Phy er this	<b> </b>	27. Manner of Death		f Injury n, Day Year)	28b. Time o		28c. Injur Wor	y at	131191101	28d. Describe h	ow injur	y occurred	Rest	депсе	
Ö	ath. or: After	atio	1 □ Matural 5 □ Pending 2 □ Accident investigation	n	i, Day rear/	Injury	М		Yes 2	No						
Division	he Hospital or Attending Physician: n 24 hours after death. he Funeral Director: After this certific clelely filled in by the funeral director.	Certification:	3 Suicide 6 Could not I 4 Homicide determined	286. Place	of Injury - At h g, etc. (Speci	nome, farm, str ify)	reet, factor	y, office			28f. Location (S City or Tow	treet an n, State	d Number or R. )	ural Route No	ımber,	
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}			1 white	ols				בע	.47	لاها		_3	-/1	06		
			30. Name and address of person who	completed cause	of death (Ite			-	<i>C</i>	0-1	Arno	1	Mp a	21/212		
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State of Maryland / Department of Health and Mental Hygiene 2 0 6 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** \_a <sup>M</sup> March Moreland 2006 9:59 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5706 Brooks Woods Road Lothian Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Oct. 30,1935 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1**√** M 2□ F Hours 215-36-4023 70 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location \*how 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Muclical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo MD Anne Arundel Lothian 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 5706 Brooks Woods Road 20711 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 Yes 2X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White δ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Grocery Stocker Retail Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elmer Moreland Margaret Stallings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra Beth Colgan (Daughter) 421 Peach Tree Lane, Yorktowne, VA 23693 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3-15-2006 Metro Crematory Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A 21. Signature of Funeral Service Licensee 3. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

3 MONTO Immediate Cause (Final **Physician** LUNG MONTRAS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DIABETES MELLIMS 1 Nes 2 No 3 Probably 4 Unknown Be Completed HYPERTENSION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL VASCULAR 2□ No 1 Yes 2 No 1 Tyes : After this certifical funeral director, p the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ☐ Nursing Home 5 PResidence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No investigation 2 Accident Diractor: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 36091 valryl MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 888 BESTLAPE RD #102 AMAPOLIS MD 21401 ANTHONY BOAKYE MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Yeer 1843 **Physician** Miller 8006 3 ouzanne Murch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🗓 F Hours Yrs. 27 3,1978 Maryland 212-17-0082 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show ury or other traumatic event, the Madical Exemines must be notified at 1 ☐ Yes 2 ☑ No Director MD Anne Arundel Lothian 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26 Batchelors Choice Lane 20711 USA Funerai 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. l □Yes 2 No fYes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Allied Waste 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Nancy Crumrine Richard Talbott Miller ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 Batchelors Choice Lane, Lothian, MD 20711 R. Talbott Miller (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 3-15-2006 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility
Hardesty Funeral Home, P.A.
12 Ridgely Avenue, Annapolis, MD 21401 21. Signature of Funeral Service Licensee 70 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 20 months toute Lymphoblastic
Due to (or as a consequence of): **Physician** Houte disease or condition /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physicien and as the burial-transit the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending F IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 No certificate 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No dire 0 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 Tyes 2 No 2 Accident . 24 hours after deat e Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) icai 29a. Certifier (Check only one) and manner stated. within 2. To the I 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier 2 RES-000 March 13 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Walfe Greet Baltimore Maryland 21287 The Johns Hapkins Hospital Michael Fradley 31. Data filed (Month, Day, Year) 32. Registrac's Signature State MAR 6 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 03 MAR EZEQUIE OPEZ 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner LINTON MD MARYLAND HOS PRINCE GEORGES DITAL CENTER 20735 If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1X M 2□ F Months Director NONE MAR.17,2006 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Exercities must be notified at 1 ☐ Yes 2 📉 Funeral Director MARYLAND CHARLES HUGHESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 15425 HOMELAND DRIVE 20637 U.S.A. tems 23a 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes XIXNo If Yes, Give Year or Dates: X□XNever Married 2 Married 5 1 ☐ Yes 2 ☒ No Be Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lightly or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EZEQUIEL LOPEZ MAR KATRINA YUVONNE GHAFFAR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15425 HOMELAND DR., HUGHESVILLE, MD 20637 KATRINA GHAFFAR- MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State OF PEACE CEM. OUEEN 3-23-06 HELEN, MARYLAND \* 4 ☐ Donation 5 ☐ Other (Specify) MO(0478) 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, 21. Signature of Juneral Service Licensee P.A. LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congenita **Physician** 10mb /Medical Due to (or as e consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit and Due to (or as a consequence of): physician Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 🗌 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Munknown 1 ∏ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autonsy performed? 1 Tes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Medicai Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred After t Injury at Work? 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e Place of Injury - At home, farm, street, factory, office 28f Location (Street and Number or Bural Boute Number

or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after dec. filled in by within 24 hours a To the Funeral (

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

☐ Homicide determined building, etc. (Specify)	City o	or Town, State)
Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, death occur  (Check only one)  Certifying Physicien: To the best of my knowledge, death occur  (Check only one)		
Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
· W	D54760.	3/17/06
ame and address of person who completed cause of death (Item 23a) (Type, Print)		CUNTON 1
MEENAKIHI CHANDRASEKARAN	SOUTHERN MARYLAND	HOSO CENTER, 20735

State Registrar 4 Hor

29a. Certifie (Check one) 29b. Signatu

30. Name at

32. Begistrar's Signature

31. Date filed (Month, Day, Year)

State Registrar AYIM

AKYER - DJAMSON, 4000 MITCHELLUICE RD SITTE 406, BOWIE, MD 2076 31. Date filed (Month, Day, Year) MAR 1 7 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0050898

29d. Date signed (Month, Day, Year)

March 11, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Willie Pinkard, Jr. March 14, 2006 5:30 A. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Southern Maryland Hospital Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7/17/25 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 XM 2 ☐ F Lorain, Ohio Director 295-14-9713 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "naturef", or Items 23a or 28a-f show other traumatic event, the Modical Exeminal must be notified at M☐Yes 2 ☐ No Director Md. P.G. Clinton 10e. Street and Number Of. Zip Code 10g. Citizen of What Country? 7207 Branchwood Place Completed by Funeral 20735 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and 1 fem 27 is marked other than "natural", or items 23. U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1▼]Yes 2□ No If Yes, Give Year or Dates:WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married African-Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cement Worker 11th Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willie Pinkard, Sr. Carrie Lee Reynolds 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7207 Branchwood Pl., Clinton, Maryland 20735 of Disposition (Name of Date 20c. Location - City or Town, State Helen Pinkard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 6 1 

Burial 2 □ Cremation 3 □ Removal from State Department of Important: If sny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. GArdens 3/18/06 Waldorf, Maryland H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 21. Signature of Funeral Service Licensee any now 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Candiovarcelon Di Slave Athenosclosetic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) cete has been signed by the e page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificete 2 No 1 Yes 2 No 1 Tyes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: Certification: To 2 ER/Outpatient 3 DOA 1 | Inpatient this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 2 Accident 5 Pending s after deeth. 1 Yes 2 No investigation M the 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours 29a. Certifier Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical сптрletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 195365 30. Name and widress of person who completed cause of death (Item 23a) (Type, Print) mita Notto for worksta Mr.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 1 7 2006

32. Registrar's Signature

		_	1 - For State Registrer	State of Marylan		artment of			Re	g. No.	06	10077
	Physici	an	Decedent's Name (First, Middle, Last)  Teka Purvi						Date of Deat	Day	Year	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give			4h City Town	n, or Location of		March	4c. Count	QOOC Of Death	1.10 /1
,	Examin	ier	Union Memorial Ho				imore				,	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye	ar If Under 24	4 Hrs. 8.	Date of Birth	Year)	9. Birth	place (State or Foreign
	Director		100 00 1122	M 2DF 33	Yrs.	WOTHING Da	ys	19(31).	Date of Birth (Month, Day, 10/14/	1972	New	Jersey
	and		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	10d. Inside City Limits
	Maryl f •hc	ō	D.C.	ī	Washin	gton						1 XYes 2 ☐ No
	r 28a	Director	10e. Street and Number			10f. Zip Cod	8		1	0g. Citizen of	What Cou	ntry?
	death with the Maryland me 23a or 28a-f ehow rimus be polified at	a D	1454 V Street, S.E	•		20	020			US	A	
	r dea	Funeral	T. Maria States	<ol><li>Was Decedent Ever in U. Armed Forces?</li></ol>	S. 13. \	Was Decedent of f Yes, specify C	of Hispanic Origi Suban, Mexican,	in? (Specify Puerto Ric	y Yes or No- an, etc.)		ce - Ameri ck, White,	can Indian, etc.
9	rs afte	by Fi	1∑ Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ <b>X</b> No If Yes, Give Year or Dates:		1 □ Yes 2 🟋	No Specify:			Specia	fy:	1-
21215-0036	2 hour		15. Decedent's Edu	cation	16a. Deced	ient's Usual Oc	cupation			16b. Kind of E		ack Idustry
נט	hin 72	Completed	(Specify only highest grade Efementary/Secondary (0-12)	e completed) College (1-4or 5+)	(Give	kind of work do DO NOT use rei	ne during most ( tired)	of working				·
N	ed wil	Con	12th		Nu	rsing A	ssistant				Priva	te
yland	be fil hta! H od oth	Be	17. Father's Name (First, Middle, Last) Willie M. Jackson					's Name <i>(F</i> Ol Pu	First, Middle, M	Maiden Sumai	ne)	
Ĕ	houid d Mer marke	5	19a. Informant's Name/Refationship (Ty		19h Mailir	na Address (Sta	eet and Number			City or Town	State Zii	Code)
<u>8</u>	nd 2 s lith an 27 is r trau		Carol Purvis - Mot				st Stree				212	
e,	es 1 a of Hea of Hea of Hea of Hea rothe		20a. Method of Disposition  1 Description   3 Period   3 Period	1 ~	lace of Dispo emetery, cren	sition (Name of natory or other)	place)	Date	9	20c. Location	- City or T	own, State
Ě	Pag ment tent: h		4 Donation 5 Other (Specify)						/2006	Brenty	vood,	Maryland
Баппо	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Inportment if them 27 is marked other than "naturel; or itame 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be notified at once.		21. Sign ture of Funeral Service Licenso	9 M (1 M )			dress of Facility	Free	man Fui		Servi	ces
			23a. Part1. Enter the disease, or compli	cations that ceused the deat			416; Sui			20752		Approximate
	Physician		shock, or heart failure. List only or fmmediate Cause (Final	ne cause on each line.								Interval Between Onset and Death
/	/Medical		disease or condition resulting in death)	Due to (or as a consequence	uence of):	Detro	escy S	4700	00-6			unknown
	Examiner		Sequentially list conditions,	END STAC	SE DE	MAC '	DISEAS	€.				
7	ped list	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence of):							
<u>.</u>	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a consequ	uence of):							
00/8	cate be executed bhysician and the burial-transit	edical		1								
Ď	certificate Iding phys	Med	fF FEMALE:									
X Q Q	death ce	lan/	23b. Was decedent pregnant in the past 12 mg/hths?	3c. ff yes, outcome of pregna 1☐Live birth 2☐Feta	fdéath 3□	Ectopic pregna					ate of deliv	ery Day Year
	the de / the a ched f	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of di 9□ Unknown	eath 5∟	Other (specify	)					,
 7	requires that the death certific een signed by the attending p nould be detached for use as	by Ph	Part If. Other significant conditions cor	ntributing to death but not res	ulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use con	tribute to t	he cause of death?
Hecords	w require been sig should b								1 □ Y∈	s 2 🗆 No	3 Pro	bably 4 Unknown
ပ	law as b	plet							24a. Was a		Were auto	opsy findings available empfetion of cause of
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UNISION	r Atter	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At he building, etc. (Specif		eet, factory, offi	ce	28f	Location (St City or Town	reet and Num	ber or Rur	al Route Number,
2	oital o urs aft real Di	O										
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wiedge, death tion and/or in	occurred at the vestigation, in n	e time, date and ny opinion, death	place, and noccurred	d due to the ca at the time, da	iuse(s) and mate and place	anner as s , and due t	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2	_	29c. Lic	ense number		2	9d. Date sign		Day, Year)
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R	_		30. Name and address of person who co				M = 0	, 1	Auc 7	2.14 0.	10 3	12.(0
	Sta	to	DALJEET SALC 31. Date filed (Month, Day, Year)	Registrar's Signa		EST	MT Rec	14(	100	-17 VV	12 2	1-1/
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 25, Da 2006 Year **Physician** 2022 Linwood D. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 7. Age (In yrs. last birthday) 70 Yrc If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Hours 1**2** M 2 □ F Virginia 212-32-9810 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r then "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Aberdeen Director Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21001 18 Poplar Grove Ave. e filed within 72 hours after death is Hygiene.
other then "naturel", or Items 23. Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1XI Yes 2 No
If Yes, Give
Year or Dates: 1956-63 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 12 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil ment of Health and Mental H lant: If item 27 is marked otl Annie L. Goodwin Otis D. Pace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau 18 Poplar Grove Ave., Aberdeen, MD 21001 Mary Ann Baublitz (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State R. A. Ferris & Co. 3/30/06 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Tarring-Cargo Tuneral Home, P.A. Aberdeen, Maryland 21001-3399 21. Signature of Funeral Service Licenses 23a. Part I. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on jach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). Examiner Sacuentially fist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner igned by the attending physician and be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 And 3 Probably 4 Unknown ace, Linwood 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🖳 MG 26. Place of Death | Check only one) 25. Was case referred to medical Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2☐ No 2 ER/Outpatient 3 DOA Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Direct completely filled in by the 4 | Homicide 0 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29b. Signature and title of certifier death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

		•	For State Registrar	State of		d / Depa		t of H	ealth a		ental Hyg		06	0079
	/ <del>-</del> -	* 3	Decedent's Name (First, Middle, L	.ast)							2. Date of Dea		Year	3. Time of Death
	Physici /Medio	_	Norman	L.	Plott						March	13, 2	2006	3:15 P M
	Examir		4a. Facility Name (If not institution, g				-		Location of			4c. Coi	unty of Death	
		-	Calvert County	Nursing (	Center		Pr	ince	Free		k		Calv	ert
	Funeral Director		224-05-7711	Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. I.	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 30	, 190	Cou	place (State or Foreign Irginia
	and w	}	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Le	ocation							10d. Inside City Limits
	ne Marylan Ba-f ehow	ctor	MD Calv	ert	P	rince			\$			0	(111)	1 ☐ Yes 2 ☒ No
	with th	급	10e. Street and Number	a d			10f. Zip	678				iog. Citizen	of What Cou USA	ntry r
	e 23	eral	85 Hospital Ro	12. Was Deced	ent Ever in U	S 13			spanic Ori	inin? (Spe	acify Yes or No-	14.	Race - Ameri	can Indian.
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Exacinar must be notified at	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Force	es? <b>X</b> ) No	3.	If Yes, spec				ecify Yes or No- Rican, etc.)		Black, White, ecify: Whi	etc.
5-0	72 hc	etec	15. Decedent's (Specify only highest of	Education grade completed)		(Give	dent's Usua kind of wor	rk done c	turina mos	t of worki	ing	16b. Kind	of Business/Ir	ndustry
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Nar	12 sho h and h and 7 ie mu trauma		19a. Informant's Name/Relationship				3	•			al Route Numbe esapeake			20732
	1 and 1eattl 1 am 27 1 ther t		Robert W. Plott 20a. Method of Disposition		20b. P								ion - City or T	
Baltimore,	ages or of		1 ⊠Burial 2 ☐ Cremation 3		ale	tace of Displanetery, cre					n 18,			Virginia
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Ba	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is eny injury or other tra 2000		Mary J. Go	ff		{	8125 8	South	iern	Mary	land Bl	vd. (		, MD 20736
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List on tmmediate Cause (Finat disease or condition	ly one cause on each	' 3	SIME		e or ayın	g, such as	cardiac	or respiratory ari	est,		Approximate Interval Between Onset and Death
7	/Medical		resulting in death)	aDue to (o	r as a consequ	-	300							1010107
	Examiner		Sequentially list conditions	b										
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	ianea of):								
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Duc to (a									-	
760,	oe execian g		rossing in county and	Due to (o	r as a consequ	uence or):								
687	cate b	dlcal		d			· · · · · · · ·							
Box.	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		th 2 ☐ Feta nt at time of de	death 3	□Ectopic pr □ Other (sp					23d	I. Date of delive Month	very Day Year
s, P.O.	w requires that the been signed by the should be detached.	by Ph	Part II. Other significant condition	s contributing to dea	ith but not resi	ulting in the	underlying c	ause giv	en in Part	l.				the cause of death?
ğ	en sig	led									1 🗆 Y	es 2□N	No 3∏Pro	bably 4 Miknown
I Records,	The law ate has b page 2 st	Somple									24a. Was a autop perfor	sy med?	prior to c death?	opsy findings available omptetion of cause of
Vital	Phyeician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			- Invite	*10,00			e of Deat	h Check only o	nel		
× ×	Phyeia this carriers and dire	2	1 ☐ Yes 2 ☑ No		patient 2				4 2 141	-	me 5 Resid			ıfy)
ū	ing P	00:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		Injury , <i>Day Year)</i>	28b. Time ( Injury		28c. Injur Wor	k?		28d. Describe h	ow injury o	ccurred	
isio	Attending r death.	cat	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could no	t ho	of Imiumu At Inc	ma form o	M factor		Yes 2	NO	28f Location /9	Street and N	Jumber or Ru	ral Route Number,
Division of	after after Direct Dire	Certification:	4 ☐ Homicide determin		of Injury - At ho g, etc. <i>(Specif</i>		rreet, ractory	y, omce			City or Tow		10111001 01 1101	a risute rumos,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C		Physician: To the base	sis of examina									
	To the within To the comp	M	29b. Signature and title of centries	M Ru	X P				e number 96:	57		29d. Date s	signed (Month)	n, Day, Year)
•	2		30. Name and address of person we Charles Judge,		Hospita		, Print)				k, Mary	land	20678	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Re										
	, i		INIHIT	T O F400,	A STATE OF THE PARTY OF THE PAR		-/-							

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23e or 28e-1 show any injury or other traumatic avent, the Medical Examinar must be inclined at once.		Director	
	Dailinore, maryland 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than *natural; or itame 23s or 28a-f show any injury or other traumatic event, the Medical Examinant be inclined at once.	•

			<ul> <li>Hegistrar</li> </ul>				00,1	1110010	D 0 4		110	g. No.		
	23 N 20 W.		1. Decedent's Name	e (First, Middle, Las	st)						Date of Deat			3. Time of Death
	Physici	an	т 1	. 0 D							Month arch	Day 7	2006	7:00A M
	/Medic	al	Isado		aynter			41 O's Town	-1ti4 C		11 011	4c. County		
1	Examin	er	, 101		street and number)			4b. City, Town, o						
		24	13713 No	rth Gate	Dr.				Spring	g		Mont		
	Funeral		5. Social Security N			e (In yrs. last	birthday)	If Under 1 Year Months Days		Min. 8. C	Date of Birth	Year)	9. Birth	place (State or Foreign
A.	Director		577-60-2	900   1	□M 2DF	80	Yrs.	Working Days	110010	Fe	eb. 15	, 1926	Was	place (State or Foreign intry) hington, DC
	D		Usual Residence of											
	lan w		10a. State	10b. County		10c. City, To	own or Loc	ation						10d. Inside City Limits
	Man	ō	MD	Montgom	erv	Sil.	ver S	nring						1√2 Yes 2 □ No
	28a	ec	10e. Street and Nu		icly	1 211	VEI D	10f. Zip Code			1	0g. Citizen of \	What Col	intry?
	diff.	Funeral Director			_				0.6					,
	ath 7	ra		rth Gate				209				United		
	eb n	ure	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. W	as Decedent of H Yes, specify Cubi	lispanic Origin an, Mexican, F	n? (Specify Puerto Rica	Yes or No- n, etc.)		e - Amer ck, White	ican Indian, , etc.
9	or it	Ę		ied 2 ☐ Marned	1 ☐ Yes 2 🔯 I If Yes, Give	No	1	☐ Yes 2⊠ No	Specify:			Specifi	· Af	riçan-
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menial Hygiene. If marked other than "natural", or itsme 23a or 28a-f show other traumatic event, the Medical Examinal must be inclined at	by	3 X Widowed	4 Divorced	Year or Dates:							Spoon,		erican
9	72 h	Completed	/Sne/	15. Decedent's Ed	ducation	1	6a. Decede	ent's Usuaf Occup	ation	f working		16b. Kind of B	usiness/l	ndustry
Ę	Ne The	pie	Elementary/Seco	-	College (1-4or 5	5+)	life. D	O NOT use retire	d)	" Working				
7	filed withii Hygiene. other then ent, the M	Eo	12	7110019 (0 12)	College (1 401 c	.,	S	ecretary				U.S. G	over	nment
0	Hygie Hygie other		17. Father's Name	(First, Middle, Last)	1				18. Mother's	Name (Fir	st, Middle, I	Maiden Suman	ne)	
a	should be Ind Mental I	Be	John	R. Cooper					C1:	arabe	11e F1	low <b>e</b>		
Š	Me Me	2		<del>_</del>		1	101 14 11	444 (2)					Ctota 7	in Cordal
a	2 should be filed withir and Mental Hygiene. is marked other than surnatic avant, the Ms		19a. Informant's N	ame/Relationship (	**			g Address (Street						
	and n 27 er tu		Joanin <b>e</b>	J. Paynt	er (Daug			Kayson	St., S					906
ē	t He to the		20a. Method of Dis			20b. Place	e of Dispos etery, crem	ition (Name of atory or other pla	ce)	Date		20c. Location -	City or 1	Town, State
E C	Sent of			☑Cremation 3 L 5 ☐ Other (Specif	Removal from State			e Cremat		3/10/	06 1	Beltsvi	11e,	MD.
₽	T La ST			neral Service Licer				Name and Addre	-			1 C		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trae		<b>1</b>	0.1	1/	100								
			Cu	rocre o	- wanys			400 Geor				Vash. D	C Z	0012
ı.			23a. Part1. Enter t shock, or hea	the disease, or <i>co</i> m art failure. List only	plications that caused one cause on each li	d the death. [ ne.	Do not ente	or the mode of dyir	ng, such as ca	irdiac or res	spiratory arri	est,		Approximate Interval Between
	Physician		Immediate Cause disease or condition		Respir	atory 1	Failu	re						Onset and Death  1 week
	/Medical		resulting in death)		a	a consequen								2 ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Examiner				Cervic									8 months
		-	Sequentially list co	onditions,	D	ar Cant								O MOHENS
	ad sit	in	if any, leading to in cause. Enter Unde Cause (Disease or	erlying	200 10 (01 00	a consequent	00 017.							
	acut tran	Examiner	that initiated event	S	c									
Ó,	an a	ũ	resulting in dealing	Last	Due to (or as	a consequen	C9 Of):							
68760,	th certificate be executed lending physician and r use as the burial-transit	an/Medical		•	d									
99	iffica g ph as th	ed									<del></del>			
Вох	ndin use	2	IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outcome			1 6				23d. Da	te of deli	
m	etter for u		in the past 12	months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnance Other (specify)	у			Mo	onth	Day Year
P.O.	The law requires that the death cert ate has been signed by the ettendin bage 2 should be detached for use	Completed by Physic	1 ☐ Yes 2 l 9 ☐ Unknown		9□ Unknown			J. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.						
0	d by	P.	Part II Othor signi	figant conditions	contributing to death b	out not cocultin	a ia tha ua	dorh ing cours an	on in Part I		23e Did tol	Dacco use con	tribute to	the cause of death?
	es the	ρ	Faith. Other signi	ilicant conditions (	contributing to death t	out not resultin	ig in the un	idenying cause gi	reitiii raiti.					
5	w requir been si should	pa									1 L Y	as 214No	3   Pro	obably 4 Unknown
S	s be	Set									24a. Was a	n 24b.	Were au	topsy findings available completion of cause of
Re	he la e ha	Ē									autops perforr	ned?	death?	
<u>_</u>	icate												1 U Yes	2 ☐ No
/it	ciar	Be	25. Was case reference examiner?	rred to medical	Nonstati						heck only on			
£	Physician: this certificant	ပ္	1 ☐ Yes 2🗶	No	Hospitaf: 1   Inpatio		/Outpatient					ence 6 □Oth		city)
Division of Vital Records,	ter t		27. Manner of Dea 1 X Natural	th 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28 av Year)	b. Time of Injury	28c. Inju Wo	ry at rk?	28d.	Describe ho	ow injury occur	red	
ō	ath.	atic	2 Accident	investigatio		, ,	,		Yes 2 □No	0				
/is	Attending r death.	ţ;	3 Suicide	6 Could not b determined	280. Place of in	jury - At home	, farm, stre	et, factory, office		28f.	Location (Si	reet and Numi	ber or Ru	ral Route Number,
S	or after	Certification:	4 🗌 Homicide	00.011111100	building, et	tc. (Specify)					City or Towi	n, State)		
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier	12 Cartifulne Di	nysician: To the best	of my knowle	diegh anh	occurred at the ti	me date and	niace and	due to the o	ause(s) and m	anner ac	stated
	Hos Fun Fun tely	Ca	(Check only		niner: On the basis of	of examination								
	the the the	Medical	one)	t title of	and manner st	ateu.		00+ Linc-	a number			9d. Date signe	d /Adon	Day Vess
	To Will	1	29b. Signature and	THE OF COUNTY				29c. Licens						
	12			X >	~			MD	19002			March	9, 2	006
-	( -		30. Name and add	ress of person who	completed cause of	death (Item 23	Ba) (Type, F	Print)						
				y Y. Lin,				ania Ave	N W	Wasi	hinata	n D C	. 2	0037
15	Sta	ato	31. Date filed (Mor			rar's Signature		LIII AVE	- T4 • A4 •	wasi		υ ο U ο U	•	JJJ1
~	Regist				2006	w to	A	and						
	, ,						# /							

DHMH 17 Rev 1/2001

		_ For	partment of Health and Nertificate of Death	Mental Hygiene Reg. No. 006	10081
Physici		1. Decedent's Name (First, Middle, Last)  Mary Evelyn Pike		Date of Death Month Day Year March 21, 2006	3. Time of Death 3:00 A M
/Medic Examin	_	4a. Facility Name (If not institution, give street and number)  St. Mary's Hospital	4b. City, Town, or Location of Death Leonardtown	4c. County of Dea St. Mary	th
Funeral Director		5. Social Security Number  6. Sex 1 M 2 M F  7. Age (In yrs. last birthd	Months Days Hours Min.	8. Date of Birth 9. Bir (Month, Day, Year) 0ctober 18,1920 Virg.	thplace (State or Foreign ountry) inia
Maryland -f show line at	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or           Maryland         St. Mary's         Holl			10d, Inside City Limits 1 ☐ Yes 2 No
with the sor 28a	Direc	10e. Street and Number	10f. Zip Code	10g. Citizen of What Co	ountry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Exertil set matified at ange.	d by Funeral Director	23588 Three Notch Road  11. Marital Status  1 Never Married XXMarried 3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married XXMarried If Yes, Give Year or Dates:	20636 3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Specify:	
21215-1-	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	icedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	16b. Kind of Business Own Hom	•
Maryland 2  td 2 should be filed  th and Mental Hyg  27 Is marked other  traumatic event,	To Be C	17. Father's Name (First, Middle, Last)  Raymond Bradsher	18. Mother's Nam Emma T	ne (First, Middle, Maiden Surname) homas	
Mal th and th and traum			ailing Address <i>(Street and Number or Ru.</i> 38 <b>Three Notch Road, Hol</b>		
Dallimore, sermit. Pages 1 an Department of Heal mportant: if item 2 nny injury or other		20a. Method of Disposition  1XXBuriai 2   Cremation 3   Removal from State	sposition (Name of crematory or other place)  Mat	Date 20c. Location - City or Ch 2006 Pikeville, No	Town, State
permit. Popartm Importation any injure 2005.		21. Signature of Funeral Service Licensee  Thuckas Neura Hardener	Mattingley-Gardiner Fur P.O. Box 270, Leonardto	neral Home, P.A.	
Physician /Medical Examiner pur	Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events c.	enter the mode of dying, such as cardiac Nearl-Failu Failu	or respiratory arrest,	Approximate Interval Between Onset and Death
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Medical Ex	Due to (or as a consequence of):  d	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of de Month	Day Year
w requires that been signed should be det		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death? robably 4 Kunknow
The law rate has be page 2 sh	Completed			24a. Was an autopsy performed? death?  1 Yes 2 No 1 Yes	utopsy findings availab completion of cause of s 2 No
for Attending Physician: The law requires taller death.  Director: Afler this certificate has been signe in by the funeral director, page 2 should be	ation: To Be	25. Was case referred to medical examiner?  1	tient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Spe 28d. Describe how injury occurred	acify)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or R City or Town, State)	lural Route Number,
Hosp 24 hou Funer etely fill	edical	(Chack only one)  Contrying Physician: T. the best of my newledge of Medical Examiner: On the basis of examination and/cone)	eath occurred at the time date and clace or investigation, in my opinion, death occu	and due to the nause(s) and manner s rred at the time, date and place, and du	e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier  ASUAL	29c. License number  H706	29d. Date signed (Mon	
St	ate	30. Name and address of person who completed cause of death (Item 23a) (Ty Dr. A.D. Shah St. Mary's Medical Arts Bui.  31. Date filed (Month, Day, Year)  MAR 2 1 2006	lding, Leonardtown, Mary	yland 20650	

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylan	•	artment of H rtificate of		nd Mental	Hygier Reg. 1	4000	10082
	_		Decedent's Name (First, Midd)	le, Last)						of Death		3. Time of Death
	Physici	an			Pritche	tt			Mont		y 2006	11:12 A M
	/Media		4a. Facility Name (If not institution				4b. City. Town, o	or Location of I			4c. County of Death	
	Examir	ıer	Talbot Hospice	1000	,,,		Easto				Talbot	
			5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year		Hrs. 8. Date	of Birth	9. Birth	place (State or Foreign
	Funeral Director		214-18-4012	1 □ M 21∏ F	81	Yrs.	Months Days	Hours	Min. (Moni	of Birth th, Day, Yea 22,1	924 Mary	land
			Usual Residence of Decedent				<u> </u>					
5	ylanc		10a. State 10b. County	1	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
$\gamma$	Mar Fer	ţō	Maryland Dorche	ester		Crapo						1 ☐ Yes 22 No
7	r 28e	Director	10e. Street and Number				10f. Zip Code			10g. (	Citizen of What Cou	ntry?
3	h witt	<u>E</u>	2360 Andrews R	oad			21	626			USA	
0	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show to Maricel Examiracing Bellon invitified at	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U	.S. 13.	Was Decedent of I	dispanic Origin	? (Specify Yes	or No-	14. Race - Ameri Black, White.	
9	after or ite	Ē	1 ☐ Never Married 2 ☐ Mar		2 📉 No		1 ☐ Yes 2 ☒ No		dente moan, ot	0.,	0	
03	el', c	by	3 Nidowed 4 Divorced	Year or D	ates:		ILITes Z <u>w</u> iNo	Specily.			Specify:	White
21215-0036	72 ho	Completed by	15. Deceder	nt's Education est grade completed)		(Give	dent's Usual Occup	durina most o	f working	16b.	Kind of Business/Ir	ndustry
21	thin e.	du	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life.	DO NOT use retire	d)			<i>5</i> 1	
	ygien /gien ler th	Co	12			Crai	Picker	1			eafood	
pu	al Hy d oth	Be	17. Father's Name (First, Middle						Name (First, N		en Sumame)	
/la	Ment Ment arke	ပို	Willis Jester	Windsor				Mildr	ed Tawe	S		
Maryland	sho and is ma		19a. Informant's Name/Relation.								y or Town, State, Zi	o Code)
	and and alth		Kathy Robinson	/Daughter		_		Road,			and 21626	
ore	of He of He iten		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 Damousl from	1 6	Place of Dispo cemetery, crea	osition (Name of matory or other pla	ce)	Date	20c.	Location - City or T	own, State
Ĕ	Page nent int: If		`4 □Donation 5 □ Other (			chester	Memorial :	Park   3	/21/2006	6 Cam	bridge, N	ÍD .
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show may injury or other treumetic event. It is Marical Examination ust be multipled at Once.		21. Signalury of Fireral Service	Licenste)	elle	Z Z Z	2. Name and Addre	ess of Facility neral H	ome, P.	0. Bo	ox 207 rket, MD	21631
			23a. Part. Enter the disease, o	r complications that o	aused the deat						iket, iib	Approximate
			shock, or heart failure. Lis	t only one cause on e	ach line.		_					Interval Between Onset and Death
	Prrysician /Medical		disease or condition resulting in death)	a		mers	. <u>U</u>	EMEN	AITC			6 yrs
	Examiner		,	Due to	(or as a conseq	(uence of):						.0
1		<u>ا</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq	uence of):						
	ted	iệ	cause. Enter Underlying Cause (Discass or Injury that initiated events	<	(	,						
	cate be executed physician and the burial-transit	dical Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):						
09	be e ician buria	a E										
68760,		dic		d.								
_	death certifi e attending p od for use as	/Me	IF FEMALE:	23c. If yes, out	tcome of pregna	ancy					23d. Date of deliv	erv
Вох	ires that the death cer signed by the attendin d be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months?		ointh 2 ☐ Feta nant at time of d		Ectopic pregnand Other (specify)	y			Month	Day Year
o.	he de	ysic	1 ☐ Yes 2 🗷 No 9 ☐ Unknown	9□ Unkn			2 0 11101 (0)2001// _					
Δ.	that the ed by th detache	h h	Part II. Other significant condit	ions contributing to d	eath but not res	sulting in the u	inderlying cause gr	ven in Part I.	230	Did tobacc	o use contribute to	the cause of death?
Records,	requires een sign hould be	d b	Cereland V	lascular	Ar	LIDE	NT			1 Tes	2 XNo 3 Pro	bably 4 □Unknown
Ö	requ	Completed	11 1	Viscoley						146	Oth Wass and	anni findinan available
ec	ta 2	du	Hypertension	),					Z4a.	Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
	: The cate h	ပိ							10			2XNo
of Vital	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			01	han	f Death (Check			
of	hysic this c	ျ	1 Yes 2 Kio	, 1		ER/Outpatie	IL 3 DOA		ing Home 5			ty) Hospice Ltown
בַ	fe fe	on:	27. Manner of Death 1   Natural 5 □ Pendi	119	of Injury th, Day Year)	28b. Time o Injury	Wo			CLIDE LOW IN	njury occurred	
sio	Attending r death. ector: After y the fune	cati	2 Accident invest	tigation				Yes 2 □ No		/21		-10- + Mb
Division	or Ati	i i	4 Homicide	mined 200. Flace	of Injury - At hing, etc. (Specif	ome, farm, st fy)	reet, factory, office			tion (Street or Town, St	and Number or Rur ate)	ai Houte Number,
		Medical Certification:		W								
	Hospitel	ical	(Check only 2 Medica	ing Physicien: To the I Examiner: On the b	asis of examina							
	the hin 2 the mplet	Jed	one)		ner stated.	4	29c. Licen	so number		304	Date signed (Month,	Day Year)
	To with		29b. Signature and title of certifi	^	X	-1	Do	52)	2		1-20-20	-
			mote		Anne	WL_	V	1765	フ		- 20- 2	106
			30. Name and address of person	- 4	se of death (Iter				A	0	<u></u>	2 245-
			Timothy J	· Shier	.4	<i>y</i>	136 Lea	NUM	AUE	1 re	M NOTE	0 21655
		ate	31. Date filed (Month, Day, Year	2 1 2006 32.5	Mistrar's Signa	ature	Sold !					
	Regist	eί			- Charles And Assessment		7					

State of Maryland / Department of Health and Mental Hygiene 10083 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) JAMES, MARSHALL, PARLIER Physician 17:51 PM MARCH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CECIL ELKTON HOSPITAL UNION If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 23, 19 5. Social Security Number 222 18 0756 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 73 Yrs Director Delaware Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b County 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Cecil Marvland E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 206 Skipjack Court United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Korean 1 MYes 2 □ No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural', or iteme permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene Important: If Item 27 ie marked other than "natural", or iten any injury or other treumatic event, the Medical Examinations. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: þ 3 ☐ Widowed 4 🎇 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plant/Property Elementary/Secondary (0-12) College (1-4or 5+) Management Troubleshooter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Samuel Parlier Bertha Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance L. DeGeorge/Daughter 130 Breon Lane, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State West Chester, 20a. Method of Disposition March 20. 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co. Inc. 2006 Pennsylvania Programe and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 21. Si mature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY ANOXIC **Physician** /Medical Due to (or as a consequence of): Examiner INFARCTION MYOCARDIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes il or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD D 0063486 2006 . 18 , MARCH erson who completed cause of death (Item 23a) (Type, Print) VA HAMADEH M.D., 106 Bow Street, Elkton, Maryland 21921 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar 1-Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) REAZIN MARCH Year **Physician** 4:30 AM BETT 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Center Westminster Carrol1 Carroll Hospital 8. Dete of Birth (Month, Day, Year) May 23, 1919 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. 1 ☐ M 2 🛱 F Hours Months Days Yrs 527-22-2190 86 Kansas **Director** Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County or 28e-f show the Medical Examiner must be notified at Maryland Carroll Westminster 1 ☐ Yes 2X No Direct 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? 1736 21157 Peppermint Lane United States 23e Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Teacher County School System other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental h Ε. O'Connell Homer Hanne Marv ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any injury or other trau Reazin / Daughter Mariletta 1736 Peppermint La./ Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 04/06/2006 Arlington, Virginia Arlington National 21. Signature of Funeral Service L 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1100 N. Maple Ave. / Brunswick , MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final INTRACRANIAL HEMORRHAGE TWO WEEKS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed 2□ No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tes this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO017695 March 18, 2006 0 clan, M.D. Type. Print)
CARROLL HOSPITTA CENTER, WESTMINSTER, M.D.
2115 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) ABDALLAH J. HELOU, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 0 2006 Blow & Spark Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 5:17 p<sup>M</sup> March Sullivan Micheal Ray /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year II Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 ☐ F Yrs. 21, 1958 Washington, DC 48 Director 577-80-1150 Usual Residence of Decedent 10d Inside City Limits 10a. State 10b. County 10c. City. Town or Location r then "natural", or Items 23a or 28a-f show the Madical Examinations! be notified at 1X Yes 2 No Washington D.C. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1610 Frankford Street, S.E. #106 20020 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. a filed within 72 hours after if Hygiene.

other then "natural; or Itel 1 ☐ Yes 21X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: **Black** ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Duran Paint Co. 10 Warehouseman Department of Heath and Department of Heath and Mental Hygher I flem 27 is marked or enty injury or other town. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Eddie Pearl Sullivan Ervin Lee 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erie Sullivan/Wife 1610 Frankford St., S.E. #106, Washington, DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cem. 3/18/2006 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Decubitus Ulcers Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Malnutrition Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy ned by the atter detached for u Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Rectal Cancer page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an nas autopsy performed: 1 Yes 2X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🖾 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 4 Homicide 152 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Tayag, M.D. 1500 Forest Glen Road, Silver Spring, MD

State Registrar

31. Date filed (Month, Day, Year)
MAR 1 7 2006

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death  Certificate of Death	0086
	Physici	an		3. Time of Death
	/Medic	al	Samuel M. Sharkey Jr. March 14 2006  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of	
	Examir	er		gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth	Birthplace (State or Foreign Country)
	Director		142-01-623/ 90 Yrs. March 26 1915 M	New Jersey
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Maryl -f•hc	ţō	D. C. Washington, D. C.	1 ☐XYes 2 ☐ No
	r 28a	rec	10e. Street and Number 10f. Zip Code 10g. Citizen of Wh.	
	th with	Funeral Director	1000 Water St., S.W. 20024 USA	4
	te de e	unei	Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black,	American Indian, White, etc.
95	rs afte	by Fi	1 Never Married 212 Married 1 Yes 2 12 No If Yes, Give 1 Yes 212 No Specify: Specify: Specify: Specify: 1	white
21215 <u>-</u> 0036	ond 2 should be filed within 72 hours after deeth with the Maryland salth and Mental Hygiene.  To it is marked other than "naturel", or iteme 53s or 28s-f show nor traumatic event, the Mucilcal Examination must be notified at	ted		ness/Industry
215	P	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	
2	od wil	Con	4 Journalist Journa	
7	be fill do of or	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
2	hould d Mer nark	၉	Samuel Miller Sharkey Ernestine Lawrence Robbi  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St.	
Z	id 2 slith an 127 le r		Marilyn M Sharkey - spouse 1000 Water St., S.W. Washington, DC 2	
Raltimore Meryland	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Month Hygiene.  Department of Health and Hygiene.  Department of Hygiene.		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Ci	
E	Page nent o		1 Burial 2 © Cremation 3 Removal from State 4 Donation 5 Other (Specify) Everly Crematory 3/24/2006 Alexandri	ia, VA
=	mit. ppartm ponta y inju		21. Signature of Fundal Service Licensee 22. Name and Address of Facility Everly Wheatley Fun	neral Home
α	88888		1500 West Braddock Rd. Alexandria	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Intra Cranial Bleed  a.	20hrs
5m	/Medical Examiner		Due to (or as a consequence of):	
70		er	Sequentially fist nonditions b. Due to (or as a consequence of):	
4	outed ad ransit	Examiner	Secuentially list nonclitions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
\$ 6	e exertian er urial-t	Ex	resulting in death) Last Due to (or as a consequence of):	
4007,	The law requires that the death certificate be executed site has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical	d	
-	certific ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date:	of dollars
7 14 Box	leath certifi ettending I for use as	Physiclan/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time of death 5 Other (specify) Month	
3	thet the d	hysi	9 Unknown	
March 14	es the igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	2.0
V V	w require been sig	ted	Stroke, Rypertension, 10 Yes 20 No 3	Probably 4 Unknown
37	e law r has be je 2 sh	Completed	24a. Was an autopsy pric	ere autopsy findings available or to completion of cause of
har h	icien: The certificete rector, pag			ath? ]Yes 2□No
Z 5	ding Physicien: The Ind. After this certificate hit funeral director, page	) Be	25. Was case referred to medical examiner?  1   Yes 2   Valor   Yes 2   Yes 2	
7 2	a Phys ar this eral dii	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	
		atlo	1 Accident investigation (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
nyeí	or Attendate death Director:	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number City or Town, State)	or Rural Route Number,
Samule	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune			
5(	To the Hospital or Attenwithin 24 hours after deat to the Funeral Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  29a. C	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier 29d. Date signed (	Month, Day, Year)
	F S F O		DOD53615 3-17.	-2006
0.1	16		30. Name in didress of corson o completed cause of death (Item 23a) (Type, Print)	
U	-6			
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 0 2006  MAR 2 0 2006	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician**  $P^{M}$ 14 2006 1:20 Inaxi Manu Shah March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 21009 Sunnyacres Road Gaithersburg Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under Months Days Hours 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🖾 F 181-42-5818 64 Director May 24, 1941 India Usual Residence of Decedent deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f ehow 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mantal Hygiene.
And 72 is marked other then "naturel", or iteme 23e or 28e-1 ehow the traumatic event, the Macina Examinational De notified at 1 ☐ Yes 2 ☑ No **Funeral Director** Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 Sunnyacres Road 20882 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: þ 3 Widowed 4 Divorced Aryan Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Clerk Insurance nt of Health and Mental Hyg : if item 27 is marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 0 Surendra S. Mehta Madhuben Shah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maun J. Shah / Husband 21009 Sunnyacres Road Gaithersburg, Maryland 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 18, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department important: if important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2006 Frederick Crematory Frederick, Maryland 21. Si vature of Tuperal Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure—List only one cause on each line. Approximate fnterval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** 5 Years Endometrial Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to innividual cause. Enter Underlying Cause (Disease or injury b. Dua to for as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant af time of death 5 Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death [Check only one] examiner Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Aftert Certification: 1 Natural 5 Pending after death. 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 24 hours after de Funeral Direct 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

Stephen P. Staal, M.D.

31. Date filed (Month AR Yez) 0 2006

1221 Mercantile Lane

ADENIE!

CHIND

gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D18219

29d. Date signed (Month, Day, Year)

March 15, 2006

Largo, Maryland 20774

DHMH 17 Rev 1/2001

**ORIGINAL** 

JOHN T. STEPNEY 06-01976 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD Unpend item# 23a, State 27, Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician John Therman Stepney 2006 12:41P MARCH 20. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner CALVERT CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Maryland 10X M 2□ F Yrs. 218-30-2565 72 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 23a or 28a-f ehow the Medical Examiner must be notified at 1 Tyes 2 No Chesapeake Beach Calvert Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20732 U.S.A. 3134 Dalrymple Road Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Farming Farmer 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event any Injury or other traumatic event Be Therlene Brown Robert Brown ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5370 Macs Hollow Road Prince Frederick, MD 20678 Marie Parker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Chesapeake Beach, MD 03/25/06 **Ernestine Jones Cemetery** 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility
Sewell Funeral Home 21. Signature of Funeral Service Licensee Slady a. 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a Hypertensive atherosclerotic cardiovascular disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Seventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physicien and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Unknown End stage disease; diabetes mellitus 1 ☐ Yes 2 ☐ No peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 \sum No has this certificate 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 N ER/Outpatient 3 ☐ DOA Other: 1 □XYes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 XNaturai 5 Pending 1 ☐ Yes 2 ☐ No death. investigation ours after death.

neral Director: A
filled in by the fu 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel within 24 hours a 23a, Cartiller Contifying Physician. To the best of my knowledge, death conumed at the time, date and place, and due to the cause(s) and manner as stated Medical c mpletely 2 Temperature (and manner stated). 2 Temperature (and manner stated). 2 Temperature (and manner stated). (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. MARCH 21, 2006 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE, MARYLAND 21201 OLLAKE

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registres s Signature

BERRY

2006▶

State of Maryland / Department of Health and Mental Hygiene 🗍 For State Registrer Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** March 19 2006 3:35A Smith Isaac /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Georges inholace (State or Foreign Pineview Nursing Home Clinton
6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Prince Futurecare 8. Date of Birth (Month, Day, Year) Birthplace Country) 5. Social Security Number **Funeral** Hours Months Days 1 M 2 □ F 721-12-3587 29,1930 Alabama Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or itema 23a or 28a-f show the Mudical Examiner must be notified at 1 XYes 2 ☐ No Director PG Temple Hills MD. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 United States 3210 Dallas Drive death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Specify. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien important: If item 27 is marked other the any injury or other traumatic event, ITE, ODGS. Brotherhood Teamsters 11 Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Waterine Drake Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3210 Dallas Drive
Tenp Dallas Drive
Maryland

20b. Place of Disposition (Name of cemetery, crematory or other place) Robert Smith /son 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 3/24/06 Lansdowne, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md.20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Ohset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day Year in the past 12 months? detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Yes 2 🗆 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one funeral director Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No investigation after death | Director: / d in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Branch Ave., Clinton, Md. 20735

DHMH 17 Rev 1/2001

State Registrar

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Laxmi 1. Date filed (Month, Day, Year) Berwa

7a M.D. 32. Regisfrar's Signature

		Unpend item # 2 1 - State Registrar	Clate of Me	Ce	rtificate of D	Death	Re	g. No.	6 10091
Physici	an	Decedent's Name (First, Middle, Landson Colors					2. Date of Deat Month March		3. Time of Death 1:59 P
/Medic	al	Roshaun Stu  4a. Facility Name (If not institution, gi	rdivant		4b. City, Town, or		rial CII	4c. County of	
Examin	er	Doctors Communit			Lanham				ce George's
Funeral Director			Sex 7. Ag 1 <mark>⊋</mark> M 2 □ F	e (In yrs. last birthday) 26 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Oct. 2,	Year) 1979	9. Birthplace (State or Forei Country) Wash., DC
me 23a or 28a-f ehow	ڀ	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limit
28a-f	Director	Md. PG		Largo	10f. Zip Code		10	0g. Citizen of Wh	
23a or 28a-f ehow				W= 0.0.4					
me 2	Funerai	8540 Largo Ce	12. Was Decedent	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe	cify Yes or No-		- American Indian,
or its		1 ☐ Never Married 2 【★ Married	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give	No	ir res, specify Cubar 1 □ Yes 2 ☑ No	Specify:	nican, etc.)	Specify:	, White, etc.
lural.	d by	3 Widowed 4 Divorced	Year or Dates:						Black
- 63	Completed	15. Decedent's E (Specify only highest gi	rade completed)	(Give	dent's Usual Occupa kind of work done di DO NOT use retired)	uring most of workii	ng	16b. Kind of Bus	iness/industry
r than the Mac	E O	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Driver			Privat	· e
ot other	0	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	(First, Middle, M		- 2
Menta	To B	Ronnie Sturdi	vant Jr.			Celest	ine Joh	nnson	
range should be many theath and Mental Hygie Item 27 is marked other to other traumatic event. In		19a. Informant's Name/Relationship		8540	ng Address (Street a. ) Largo				tate, Zip Code)
of Health Item 27 other tr		Ashanti Sturd:	ivant/wif	e Lare	Je Mary	Iand 2	1//4 _		lity or Town, State
in of the		20a. Method of Disposition 1   Burial 2 □ Cremation 3		cemetery, cre	matory or other place	9)			
rtant rtant		4 □Donation 5 □ Other (Spec 21. Signature of Funeral Service Lice		Ft Linco		3/24		Brentwo	
Department of I Important: If its eny injury or or once.		21. Signature of Punggar Service Lice	dwaro		2. Name and Address				ls F.H. nd,MD.20746
		23a. I an 1. Enter the disease, or corsock, or heart failure. List only							Approximate Interval Between
Itte has been signed by the ettending physicien and more 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions. The state of the transdate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. — Sue to (or as	a consequence of):  the contequence of):  a consequence of):					
by the ettending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)	4000-1000	March 2012	23d. Date Mont	of delivery h Day Year
signed b	<u>۾</u>	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause give	n in Part 1.			oute to the cause of death?
s been	Completed						24a. Wasa	n 24b. W	ere autopsy findings availa ior to completion of cause
ate has	E						autops perform	ned? de	ior to completion of cause⊹ lath? ∄Yes 2 □ No
	BeC	25. Was case referred to medical				26. Place of Death			2.00
this cert	70	examiner? 1∭ Yes 2 ☐ No	<del></del>	ent 2 ER/Outpatie		4   Nuising Hor	ne 5 ☐ Reside	ence 6 Other	(Specify)
er th	<u>.</u>	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time o	Work		28d. Describe ho	w injury occurre	d
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leath. for: After the funer	Certification:	4 Homicide determine	d 28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		City or Town	reet and Number n, State)	r or Rural Route Number,
after death.  Olfector: After this certification by the funeral director.		29a. Certifier 1 ☐ Cartifying F	hysician: To the best	f examination and/or in	h occurred at the tim evestigation, in my op	e, date and place, a inion, death occurr	and due to the ca	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)
24 hours after death. Funeral Director: After et al. (1997)	dical C		and manner st						
vithin 24 hours after death.  To the Funeral Director: After completely filled in by the fun	Medical C	(Check only 2 Medical Exa	and manner st		29c. License	number	2	9d. Date signed	(Month, Day, Year)
to hours afte Funerei Dir fely filled in	Medical C	(Check only 2 XMedical Exa	and manner st			·M.E.		arch 20	

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ORIGINAL

			For State Registrar	State of Maryla	nd / Depa <i>Cei</i>	artment of I tificate of	Health and <i>Death</i>		ene) (	10092
	Physici		Decedent's Name (First, Middle, Last)     Robert Joseph Sr	nith				2. Date of Death Month March 1		3. Time of Death 9:25 a M
	/Medic Examin		4a. Facility Name (If not institution, give st Washington Advent		1		or Location of Dea	th	4c. County of Montgor	
1	Funeral Director		5. Social Security Number 6. Sex 235-22-2667	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days			1925 T	Birthplace (State or Foreign Country) West Virginia
	death with the Maryland me 23e or 28a-f ehow rmst be notified at	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Prince Get		City. Town or Lo	cation	2			10d. Inside City Limits 1 ☐ Yes 2 ☒No
	with the	Director	10e. Street and Number			10f. Zip Code 20782		10	g. Citizen of Wh	
٥		Funeral	11. Marital Status  1 Never Married 2X Married	2. Was Decedent Ever in Armed Forces?	'	Was Decedent of	Hispanic Origin? ( pan, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Black,	USA American Indian, White, etc.
15-0036	72 hours after "natural", or fte	Completed by	3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade	If Yes, Give 1943 — Year or Date 1950 — ation completed)	16a. Deced	dent's Usual Occu	pation during most of we	orking	Specity:	White ness/Industry
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/land	ould be filed volud be filed varked other barked other batic event, II	To Be (	17. Father's Name (First, Middle, Last) Charles Colton Sm:	ith				ame (First, Middle, M Griffith		
Mar	and 2 shoul batth and Mg n 27 is mark er traumati	Ĭ	19a. Informant's Name/Relationship (Type Virginia Louise Si			_		Ru <i>ral R</i> oute Number, est Hyattsvi	-	
more,	L it of H		20a. Method of Disposition  1 XBurial 2 Cremation 3 XRe 4 Donation 5 Other (Specify)	emoval from State	cemetery, crer	sition (Name of matory or other pla nia Nation	al Cemeter	March 17		ty or Town, State West Virginia
palt	permit. Page Department. Important: it any injury o		21. Signature of Funeral Service License	certo	<b>4</b> 5	rancided 00 Unive	ess of all in ersity Bl	s Funeral	Home In lver Sp	nc ring, MD 20901
8/60,	law requires that the death certificate be executed as been signed by the attending physician and a should be detached for use as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consi	advence of):	ic Crsbn lwer n	ictive Li cetarta		ease,	Approximate Interval Between Onset and Death  2 & LPYS
O. Box 6	he death certific the attending p ched for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Sc. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnand Other (specify)	су		23d. Date Monti	,
rds, P.	w requires that the de been signed by the a should be detached t		Part II, Other significant conditions conf	tributing to death but not r	esulting in the u	nderlying cause g	iven in Part I.	23e. Did tob		oute to the cause of death?
al Records,	The ate h page	Completed		· · · · · · · · · · · · · · · · · · ·				24a. Was ar autops perforn 1 □ Yes 2	y pri ned? de	ere autopsy findings available or to completion of cause of ath? Yes 2 \( \text{No} \)
Division of Vital	Phy this	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho  27. Manner of Death  12 Natural 5 Pending 2 Accident investigation	ospital: 1 Nnpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	then: 4 🗆 Nursing	eath Check only on Home 5 Reside 28d. Describe ho	nce 6 Other	· · · · · · · · · · · · · · · · · · ·
DIVIS	el or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office	9	28f. Location (St. City or Town	reet and Number , State)	or Rural Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After or impletely filled in by the funer	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my k er: On the basis of exam- and manner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death oc	ce, and due to the ca curred at the time, da	tuse(s) and mani ate and place, an	ner as stated. Id due to the cause(s)
	To the state of th	Σ	29b. Signature and title of certifier	to wo		29c. Licer	i 900	l .	Δ ,	(Month, Day, Year)
	> ' '		30. Name and address of perso who con	mpleted cause of death (II	em 23a) (Type,	rint) #>	Postal.	aluc Parl	Jud .	14, 2006 20917
Section of the	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	poli	- CH	WALL TO THE	Parent Parent	

DHMH 17 Rev 1/2001

			For State Registrar	State o	f Marylar	-	artment of rtificate of		nd Mer		jiene leg. No.	06	1009	
	Dhysisi	20	1. Decedent's Name (First, Middle			0.0			2.	Date of Dea Month	ith Day	Year	3. Time of Deat	
	Physici /Medic		CANDID		ALIN	PAS				03	13	2006	1829	ЭM
	Examin	er	4a. Facility Name (If not institution,			~ C	4b. City, Town,					ounty of Deat	SOMER	2
			5. Social Security Number	6. Sex	7. Age (In yrs.	JSETIAL Jast highday	If Under 1 Year	. 44 4 4 4 4	PHYS. 8	Date of Birth				·
Н	Funeral Director		227-51-6858	1 <b>X</b> M 2□F	58	Yrs.	Months Days		Min.	(Month, Day	, Year)	BO	hplace (State or For untry) livia	eigi i
	D		Usual Residence of Decedent							,, 2,,	1711		+1 V 1 U	
	how	_	MD 10b. County Monto	romoru.		ty, Town or Lo							10d. Inside City Lin	
	8a-f	cto		jomery	10	akoma	raik						1 <b>X</b> ∑Yes 2 □	NO
	within 72 hours after death with the Maryland ane. than "neturel", or iteme 23e or 28e-f ehow the Madical Examiner must be multied at	Funeral Director	10e. Street and Number 8515 Greenwoo	d Avenu	e #1		10f. Zip Code 209				-	n of What Co Olivi	•	
	r dea	ner	11. Marital Status	Armed Fo	edent Ever in U erces?	.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican,	in? (Specify Puerto Ric	Yes or No- an, etc.)	14	. Race - Ame Black, Whit		
36	or it	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced	If Yes, Gir	/8	į.	1⊠ Yes 2□ No			vian		pecify:	White	
Ö	tural'	ed b	15. Decedent	Year or D	ates:	16a Dece	dent's Usual Occi	upation			16h Kind	of Business/	Industry	
7	in 72	ojet	(Specify only highes	grade completed)		(Give	dent's Usual Occi kind of work done DO NOT use retir	e during most ed)	of working		TOD. KHIO	Of Dusiliess	andustry	
21215-0036	l with	Completed	Elementary/Secondary (0-12)  9	College (1	1-4or 5+)	Cor	ntracto	r			Co	nstru	ction	
Maryland 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiane. Important: If Item 27 le marked other than "natural", or Iteme 23a or 28a-f show amplique, or Iteme 23a or 28a-f show any injury go, other traumatic event, the Medical Examinar must be notified at anone.	To Be C	17. Father's Name (First, Middle, L Narciso Salir					18. Mother Ju:	r's Name <i>(F</i> stina	irst, Middle, L Seja	Maiden Su as	ımame)		
Mary	nd 2 shortlith and N 27 le ma		19a. Informant's Name/Relationsh Aldo Salinas/			1	-						Zip Code <b>2</b> 0912 Park,Md	2
ē,	s 1 ar f Hea it am ttam		20a. Method of Disposition		20b. I	Tace of Disponentary created	sition (Name of matory or other pl	lace)	Date		20c. Loca	tion - City or	Town, State	
Ë	Page III.		1 ☐ Burial 2 XCremation 4 ☐ Donation 5 ☐ Other (Sp				ake Cr		/16/0	6	Bel	tsvil	le,Md	
Baltimore,	permit. Departn Imports any Inju		21. Signatur of Fungral Service	icens set		a a a a a a a a a a a a a a a a a a a	HTLTP <sup>dd</sup> 241 Co	D'RIN lumbia	ALDI a Blv	FUNE	RAL lver	SERVI Spri	CE,P.A. ng,Md209	910
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that conly one cause on e	aused the deal	th. Do not ent	er the mode of dy	ring, such as o	cardiac or re	spiratory arr	rest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition			75CLE	ROTIC	HE	ART	DI	SEA	SE	Onset and Death	1
	/Medical Examiner		resulting in death)		(or as a consec									
	Lxammer	_	Sequentially list conditions,	b	ATCA SILICAN SERVICE CONTROL	Control (A)								
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(UT as a consec	(uence of).								
	and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to	or as a consec	uence of):								
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687	ficate p physics the	edic		d										
Вох	eath certific ettending pl	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			ne				230	d. Date of del	ivery	J.
P.O. B	The law requires thet the death certificate be executed the fas been signed by the ettending physicien and tage 2 should be deteched for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ointh 2 ∏ Feta nant at time of c own		□Ectopic pregnan □ Other (specify)	cy				Month	Day Year	
	s thet ned b e dete	by Pi	Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the u	nderlying cause g	aven in Part I.		23e. Did to	bacco use	contribute to	the cause of death	?
ğ	w requires thei been signed t should be det				···········					1 □ Y	es 2 🗆	No 3□Pr	obably 4 Linkno	own
ပ္က	aw re	Completed								24a. Was a		24b. Were au	topsy findings availa	able
æ	The la	E								autop: perfor 1 Yes		death?	completion of cause	Ot
<u>i</u>	ysician: The is certificate h director, page	Bec	25. Was case referred to medical					26. Place	of Death (C	heck only of			34.	
Ž	Physic this ce al direc	70	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆	Inpatient 2	ER/Outpatier	1 3 DOA 0	ther: 4 🗆 Nur	sing Home	5 🗌 Resid	ence 6 [	Other (Spe	cify)	
0	Attending Physician: r death. sctor: After this certifics by the funeral director.		27. Manufer of Death  1 ■ Natural 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	f 28c. Inju	ury at ork?	28d	. Describe h	ow injury o	occurred		
<u>sio</u>	ttendi death. ctor: A / the fu	cati	2 Accident investig 3 Suicide 6 Could n	ation				JYes 2□N						
Division of Vital Records,	9 4 5 0	Certification:	4 ☐ Homicide determi	ned 286. Place	of Injury - At h ng, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office	ə	28f.	City or Tow		Number or Ru	ıral Route Number,	
	epital ours neral filled		29a Certifier Certifying	Physician: To the	best of my kno	owledge, deat	h occurred at the	time, date and	f place, and	due to the c	ause(s) ar	nd manner as	stated	
	To the Hoepital within 24 hours a To the Funeral I completely filled	edicai	(Check only 2 Medical E	xaminer: On the b	asis of examination	ation and/or in	vestigation, in my	opinion, deat	h occurred a	at the time, o	fate and p	ace, and due	to the cause(s)	
	To the Hoepital within 24 hours a To the Funeral Completely filled in	Me	29b. Signature and title of confifier	,			29c. Licer	nse number		4			Day, Year)	
)	3		1//	- A	9		DOO	557	18		03	113/	2006	
		Y y	30. N e and ress of person v		se of death (Iter	n 23a) (Type,	Print)	, A	المساء مرسم	~~	) [		1.	
			11 Date filed (45-44 2)	ITKES,	MD		ING TO	JUH U	100	_C>T	140	Prit	t'_	
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 15	2006	legistrar's Signa	ature	onle)							

100-20			For State Registrar	State of Maryla	and / Depa			ental Hygier	1000	10095
	Physici /Medio Examír	al	1 Decedent's Name (First, Middle, Last  OR 5  4a. Facility Name (If not institution, give	Spear	renter	4b. City/Town, o	Location of Death	March	Day Year 15 200 4c. County of Deat	
**	Funeral Director		5. Social Security Number 6. Se 217–28–2581  Usual Residence of Decedent	110 10	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yes June 23,	9. Birt 1932 Ma	hplace (State or Foreign untry) aryland
5	ith with the Maryland 23a or 28a-f show ust be notified at	Director	10a. State         10b. County           MD         Kent           10e. Street and Number	10c.	City, Town or Lo	Chester	ctown	100.	Citizen of What Co	10d. Inside City Limits 1 X Yes 2 No
3	h with	ai Dir	200 Morgnec Roa	ıd		10.1.2,5	21620		USA	,
21215-0036	after des	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Swidowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 Mo If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto F Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	e, etc.
5-0	natural',	Completed	15. Decedent's Edu (Specify only highest grad	cation le com <i>pleted)</i>	16a. Deced	ent's Usual Occup	pation during most of working d)	16b	. Kind of Business/	Industry
121	ified within I Hygiene. other then other, the Mar	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	chine ope			electron:	ics
Maryland 2	o d ab	To Be C	17. Father's Name (First, Middle, Last) Charles Christop	her			18. Mother's Name Lizzie		den Sumame)	
Man	2 sho		19a. Informant's Name/Relationship (T)			•	and Number or Rura		ty or Town, State, 2 18062	Zip Code)
	is 1 and of Health Item 27 other tr		Kevin Spear  20a. Method of Disposition	SON 20t		sition (Name of natory or other place	lve, Macun		Location - City or	Town, State
Baltimore,	Pages nent of int: If it		1 Burial 2 Cremation 3 □I 4 □Donation 5 □Other (Specify,	demoval from State	_	vatory or other plac Veterans		7/06 ਸ	urlock, I	MD
alti	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licens	:00		. Name and Addre		omas Fune		
11	207 2 2		23a. Part 1 Enter the disease, or comp	(i - a) i - a - a) - a - a - a - a - a - a - a -			st St., Ca		MD 2161:	
	Physician /Medical		shoot, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.  a. Acute	renal	- F1.72	ng, such as cardiac of	respiratory arrest,		Approximate Interval Between Onset and Death
2,	Examiner	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Dehux	ration					3 days
8760,	ate be executed obysicien and the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	sequence of):					1
.O. Box 68	The law requires that the death certifica 11e has been signed by the attanding ph 2ge 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	<i>y</i>		23d. Date of de Month	ivery Day Year
٥	s that I	by Ph	Part II. Other significant conditions co		_			23e. Did tobacc	co use contribute to	the cause of death?
ords	w requires been sign should be	ted k	COPD, chrone	e renal far	lure,	Corposi	Υ	1 ☐ Yes	20 No 3□Pi	robably 4 Dunknown
Vital Records,		Completed	erfery discore	, dishet				24a. Was an autopsy performed 1 Yes 2	prior to death?	atopsy findings available completion of cause of
Vita	siclan cartifi irector	o Be	25. Was case referred to medical examiner?	Hospital.	ER/Outpatien	0th	26. Place of Death	Check only one	e Cother (Con	alf d
ion of	Attending Physician: r death. ector: After this cartific by the funeral director, i		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year		28c. Injur		8d. Describe how i		City)
Division	tal or Atters after de al Directo	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, streecify)	eet, factory, office	2	8f. Location (Stree City or Town, S		ural Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Certification:	(Check only 2 Medical Examone)	rsician: To the best of my iner: On the basis of exam and manner stated.		vestigation, in my o	ppinion, death occurre	ed at the time, date	and place, and due	o to the cause(s)
	with To	2	29b. Signature and title of certifier			29c. Licens	51735	l l	Date signed (Moni	•
			30. Name a address of person who of	ompleted cause of death (	Item 23a) (Tvne	Print)		ļ	110	
		100 10	Frederick William 31. Date filed (Month, Day, Year)	Delboy, M.I	6602	Church I	Hill Rd.,	Chesterto	wn, MD	21620 

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 18, 2006 Eric W. Shaffer 1:41 AM 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Charles La Plata Civista Medical Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fon Country) | Pennsylvania Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 → M 2 → F 7. Age (In vrs. last birthday) Yrs. 180-68-0762 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Charles Waldorf Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2659 Hunt Place, Apt. 201 20602 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Marned 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: White 1 ☐ Yes 2 ☐ XNo Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Never Employed None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Shockey Joel Shaffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2659 Hunt Place, Apt. 201, Waldorf, MD 20602 Amanda Shaffer 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 3-23-2006 Somerset, Pennsylvania Edie Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road POB 156, Waldorf, MD 20604 Huntt Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTROINTESTINAL BLEED disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LELKEMIA 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No

**Physician** /Medical Examiner

use as the burial-transit

sete has been signi page 2 should be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

rthen "naturel", or iteme 23a or 28a-f ehov tre Medical Examiner must be notified at

Completed by Funeral Director

Be

with the Maryland

filed within 72 hours after

other then '

nd 2 should be filed alth and Mental Hygis 27 le marked other reaumatic event, II

permit. Pages 1 and 2 should be Depertment of Health and Mental Important: If Item 27 is marked teny injury or other traumatic ever 90cg.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner δ Be Completed Airs...
sr death...
//rector: After this cen....
the funeral director, p. Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

24a. Was an autopsy perform

1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No 27. Manger of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D0057518

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6104 OLD

Hein Nguyen SPRINGS, MALTLAND

State Registrar

31. Date filed (Month, Day, Year) 2006



within 24 hours after death.

To the Funerel Director: A completely filled in by the fa

			1 - For Stata Registrar	State of Maryland		artment <i>rtificate</i>			nd Me		iene	6	10097
	Control of	8	1. Decedent's Name (First, Middle, Last)					-		2. Date of Deat Month		Xear	3. Time of Death
€ ]	Physici /Medic		Mila Lane Tho	omas						March		2006	5:15P M
1 3 1 3 4 1 5 4	Examin	er	4a. Facility Name (If not institution, give si			4b. City, T					4c. County o		Coomacla
		12	5002 - 36th Place 5. Social Security Number 6. Sex	7. Age (In yrs. I	act high days	If Under 1		attsv If Under 2		8. Date of Birth			George's
All and a second	Funeral Director			M 22 F 4			Days	Hours	Min.	Month, Day, Feb. 2,	1961	Coun	Dhio
A.C.	1.		Usual Residence of Decedent										
	how		10a, State 10b, County	10c. City	, Town or Lo	cation						10	Od. Inside City Limits
	Sa-f	cto	Maryland Prince Ge	eorge's				svill	.e				1 🗗 Yes 2 🗌 No
	vith th	Director	10e. Street and Number			10f. Zip 0	Code	207	0.0	1	0g. Citizen of WI		-
	hours after death with the Maryland turel, or Iteme 23a or 28a-f ehow al Examinal must be motified at	rai	5002 - 36th Pi		2 12 1	Nas Dagada	nt of Uis	207		ofy Vos or No	Uni		States
_	Item Item	Funeral	11. Marital Status 1 1 ☐ Never Married 2 Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 \( \frac{1}{2} \) No</li> </ol>	s. 13. 1	f Yes, specif	fy Cubar	, Mexican,	Puerto F	offy Yes or No- lican, etc.)	Black	White,	ar indian, atc. i Can
20	urs af	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2	No No	Specify:			Specify:		rican
9500-91212	2 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual kind of work	Occupa	tion	of workin	0	16b. Kind of Bus	iness/Ind	lustry
Z	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)			9			
7	ygier ygier yer th			2		Off		Mana				riva	te
Maryland	should be filed within 72 hours after death with the Marylan ad Medial Hygiens.  marked at Hygiens "nature!", or Iteme 23a or 28a-f show marked other than "nature!", or Iteme 23a or 28a-f show marked other than "nature!" at the Marikal Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)  Denise B1	ann				18. Mother	r's Name		Maiden Sumame da Jacol		
Ĕ	d Med d Med mark matic	2	19a. Informant's Name/Relationship (Typ		19h Mailir	a Address /	(Street a	nd Numbai	r or Bural		City or Town, S		Code)
Š	lth and 2 s		Raymond S. Thomas	·						ttsvill		2078	•
Baltimore,	as 1 and 2 should b of Health and Ment litem 27 te marked r other treumatic e	li i	20a. Method of Disposition		ace of Dispo emetery, crer	sition (Name	e of her place	)	Da	ate	20c. Location - C	ity or To	wn, State
Ĕ	Page nent ant: If ary o		1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	moval nom State	coln M			1	3/18	/2006	Suit1	and,	MD
ğ	permit. Departr Importa any inju		21. Signatur of Foneral Service License	· Q —	22	. Name and	Addres:	s of Facility	St	ewart F	uneral I	lome	
П	20E = 9		John 1. Ste	werl, III							Wash., I	OC 20	
			23a. Part1. Ther the disease, or complic shock, or heart failure. List only one	eations that caused the death a cause on each line.	. Do not ent	er the mode	of dying	, such as c	cardiac or	respiratory arri	est,		Approximate Interval Between Onset and Death
46	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metastas		Brain	L						
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ		IIC DI	cast	-	-				
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Š,	e exe sien a urial-	I Ex	resulting in death) Last	Due to (or as a consequ	ence of);								
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× Q	eath certific attending p	· O	IF FEMALE:	lc. If yes, outcome of pregnal	nev						22d Data	of dollars	
X R R	atten atten i for u	cian	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pre					23d. Date Mont		Day Year
j.	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			3/1		700				
J.	w requires that the d been signed by the should be detached	by Physician/M	Part II. Other significant conditions conf	ributing to death but not resu	Iting in the u	nderlying car	use give	n in Part I.		23e. Did tot	pacco use contri	oute to th	e cause of death?
Hecords,	en sig									1 □ Ye	s 2 <b>X</b> No 3	3 🗌 Proba	ably 4 □Unknown
ပ္ပ	et a ca	ompieted								24a. Was a autops	n 24b. W	ere autop	osy findings available
_		Соп								perforr	ned? de	eath? □ Yes	
Vital	sicien: The ta certificate ha irector, page 3	Be	25. Was case referred to medical examiner?				100			Check only on	*		
0	Phy this ald	. To	1 ☐ Yes 2 🛣 No		ER/Outpatien						ence 6 Other		)
	ding h. After fune	tion	1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 28	C. Injury Work	at ? 'es 2 □ N		od. Describe no	ow injury occurre	a	
DIVISION	I or Attending after death. Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me, farm, str						reet and Numbe	r or Rura	Route Number,
5	ž <del>į</del> į į	Certification:	4 ☐ Homicide determined	building, etc. (Specify	)					City or Town	n, State)		
	e Hospitel 124 hours a e Funerel I letely filled		(Check only 2 Madical Examin	ician: To the best of my known or: On the basis of examinat	wledge, deatl	n occurred a	t the time	e, date and inion, deat	d place, a	nd due to the ca	ause(s) and man ate and place, ar	ner as st	ated. the cause(s)
	To the h within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.	\		License			-	9d. Date signed		
	T × T		Real and the or certifier	0 18	1	/		02516	5	2	March		
0	E	-	30. Name and a less of person who cor	mpleted cause of death (Item	23a) (Type	Print)	L				rial CII	10,	2000
_			Reginald C. C	hisholm, M.D.	2041		gia	Ave.,	N.W	. Wash.	, DC 2	0060	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0 2006	. Registrar's Signal	ure	de							

		i	1 - For State Registrer	State of	Maryland		artment of He tificate of D			iene () () ()	10098
			1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month	h Day Yee	3. Time of Death
	Physici: /Medic		Billie	Est	elle	Th	ompson		1	11, 2006	
	Examin		4a. Facility Name (If not institution,				4b. City, Town, or			4c. County of De	
			Calvert Memori					e Frederi		Calve	
п	Funeral		5. Social Security Number 215–38–6998	6.Sex 1 □ M 2 152 F	7. Age (In yrs. Ia 64	ist birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		04				May 10,	1941 6	eorgia
	ylanc how		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	e Maria	ctol	MD Calv	ert			Huntir	ngtown			1 ☐ Yes 2X No
	or 28	Oire	10e. Street and Number				10f. Zip Code		11	0g. Citizen of What	Country?
	ath w	rai	2210 Stinnett				20639	0110/0	'' M	USA	
	ier de Items	Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marrie	Armed For		5. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	ecity Yes or No- Rican, etc.)	Black, W	merican Indian, hite, etc.
36	within 72 hours after death with the Maryland ene. than "netural", or Items 23e or 28a-f show fra Madical Examiner must be nutified at	by F	3 ☐ Widowed 4 ☐ Divorced	ed 1 Tes If Yes, Give Year or Da	е		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
21215-0036	2 hou	Completed	15. Decedent	s Education		16a. Dece	lent's Usual Occupa	ition		16b. Kind of Busine	ss/Industry
215	thin 7 e. an "n	ple	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	kind of work done d DO NOT use retired)	) )	ing		
21	ed wi	Con	12			scho	ol bus di			public s	chool
nd	be fill stal H d oth	Be	17. Father's Name (First, Middle, L					18. Mother's Name			erts
ž	hould d Mer narke natic	<sup>L</sup>	Joseph Edwar  19a. Informant's Name/Relationsh		r	19b Mailir	ng Address /Street a			, City or Town, State	
Maryland	d 2 s th an t7 is r traur		Stanley R. Thom		band		-			n, MD 206	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Items 23e or 28a-1 show any injury or other traumatic avent, the Madical Examiner must be nutified at once.		20a. Method of Disposition	p.5011, 11015	20b. Pla	ace of Dispo	sition (Name of			20c. Location - City	
altimore,	Pages nent of I ent: If Its ury or o		1 ☐ Burial 2 ☐ Cremation 14 ☑ Donation 5 ☐ Other (Sp		State	-	natory or other place Sifts Regi		1-06 F	Hanover, l	MD
alti.	mit. Foorten		21. Signature of Funeral Service L			-	. Name and Addres	1-			
ä	Deparent Dep		William	K.6	lor	Ra	ausch Fune	eral Home	e, P.A.,	Owings,	MD 20736
Г			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that canny one cause on ea	aused the death. ach line.	Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Enysician:		Immediate Cause (Final disease or condition	. co	PD						Chrom'c
	/Medical Examiner		resulting in death)	Due to (	or as a conseque	ence of):					
h	Examine:	_	Sequentially list conditions, if any, leading to immediate	b. 70	bacco or as a conseque	us	2				
	ted nsit	nine	Cause (Disease or injury	0.000	or as a conseque	01100 017.					
	execun and al-tra	Examiner	that initiated events resulting in death) Last	c Due to (	or as a conseque	ence of):					
68760,	ficate be executed g physician and ts the burial-transit	edical		d							
	- D 05			1							
Вох	death certifi e attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant		come of pregnan		Ectopic pregnancy			23d. Date of	
O. E	e dea he att	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		ant at time of dea		Other (specify)			Month	Day Year
Ρ.	that the de led by the a detached t		Part II. Other significant condition	as contributing to de	ath hutmat recul	Iting in the u	aderhijaa cause awe	en in Part I	23e Did toh	acco use contribute	to the cause of death?
ds,	ires tha signed d be del	d by	Congestive	11 1	failus	_	idonying caase give	or in real case is	1 XY6		Probably 4 □Unknown
200	The law requires ite has been sign page 2 should be	Completed	Crigos, 11	VI V	,,				24a. Was a	n 24h Were	autopsy findings available
Re	he lav e has ge 2:	mp							autops perform	v prior	to completion of cause of ?
ā	ificate or, pa		25. Was case referred to medical					26. Place of Deat		/ -	es 2 No
of Vital Records,	Physician: this certific ral director,	o Be	examiner?	Hospital:	npatient 2 E	R/Outpatier	t 3 DOA Othe	VC		ence 6 Other (S	pecify)
100		T : U	27. Manner of Seath	28a. Date o		28b. Time of		1 3		w injury occurred	
ior	Attending r death. sctor: After	atio	Natural 5 Pending	ation	n, buy rouny	jury		res 2 □ No			
Division	l or Atten after deatl Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place	of Injury - At hor ng, etc. (Specify)	me, farm, str	eet, factory, office		28f. Location (St. City or Town		Rural Route Number,
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by										
	e Hospitel 24 hours a e Funeral etely filled	edical	29a. Certifier (Check only 2 Medical E	Physicien: To the exeminer: On the ba and mann	isis of examination	vledge, deatl on and/or in	n occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	ause(s) and manner ate and place, and c	as stated. lue to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and tille of certifier	and mann	ioi statoù.		29c. License			9d. Date signed (Mo	
}	F≯≓8		9/10th	111)			nox	570 -			
			30 Name and address of person y	who completed cause	e of death (Item	23a) (Tvpe.	Print)	10		mul 11)	2006
	12		Gwynelly Blats	Lau, un	110 HOSE	rital 1	d suite	310 Pri	nce Frea	len'cle M	2006 D 20678
	Sta		31. Date filed (Month, Day, Year)		egistra Signatu	ure	1 .0				
	Registr	ar	MAR	1 4 2006	filmers	1 St.	GOLLES	l:			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 12, Day 2006 Year **Physician** 2:30 Thomas Conway Thornton рм /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 20. 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1⊠M 2□F 1920 Washington, 85 Director 577-14-5656 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State il Hygiene. | other than "netural", or items 23a or 28a-f ehow | vent, tra Mudical Examinan must be notified at 1 □Yes 2 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 USA 4113 Fogel Lane Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2K Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Title 1 Insured Loan Division Federal Government/F.H.A. ulth and Mental Hygie 27 is marked other it traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Moore Thornton Catherine Edna Moroney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4113 Fogel Lane, Silver Spring, MD 20906 permit. Pages 1 and 2
Department of Health a
Important: If item 27 ie
eny injury or other trai Elsie Thornton/ Wife March 22, 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis Apressofinins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Kuhard L Llakes Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 Weeks **Physician** Respiratory Failure /Medical Due to (or as a consequence of): Pulmonary Fibrosis Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of). Examine anding physician and use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 ☐ Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Possible Pneumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 15 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tes 2√ No this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 K Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D36252 March 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11501 Georgia Avenue, #515, Wheaton, MD 20902 Steven Kariya, M.D.

State

Registrar

31. Date filed (Month, Day, Year)

15

5008

32 Registrar's Signature

			For State Registrar	State of Ma		partment of F e <i>rtificate of</i>	Health and Mo <i>Death</i>	ental Hygie Reg.	1. 4 4 4	10100	
	Physici	an	Decedent's Name (First, Middle, Last)	М П.1	. 1 . 1 .			2. Date of Death Month	Day Year	3. Time of Death 8:10	
	/Medio		4a. Facility Name (If not institution, give str	May Tol	odziecki	4h City Town	or Location of Death	March 2	0, 2006 4c. County of Death	0.10 A M	
	Examir	er	St. Mary's Hospita			Leonar		S			
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	St. Mary'	place (State or Foreign	
L	Director		217 21 7730	4 2 X F	78 Yrs.	Months Days	Hours Min.	(Month, Day, Year) ecember 9,1927 Maryland			
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits	
	Mary a-f sh	tor	Maryland St. Mary'	s	Hollywo	od				1 ☐ Yes 2x No	
	th the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	ntry?	
	238 c	alc	24692 Blackistone R	oad		20636			USA		
	er dea	Funeral		. Was Decedent E Armed Forces?	ver in U.S. 13	. Was Decedent of h If Yes, specify Cub	Hispanic Origin? (Specian, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	can Indian, etc.	
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show ont, the Medical Ezan in a finast be rediffed a	by F	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	0	1 ☐ Yes 2√2 No	Specify:		Specify: Whi	te	
200	72 hou natura	Completed by	15. Decedent's Educa (Specify only highest grade	tion	16a. Dec	edent's Usual Occup	pation	168	. Kind of Business/In		
Maryland 21215-0036	vithin ne. han "r	mple	Elementary/Secondary (0-12)	College (1-4or 5	+) /ife	DO NOT use retire	during most of workin d)				
io D	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Hom	emaker	18. Mother's Name		wn Home		
au	ld be ental ked o	To Be	Frederick Garheart	Sandare			Violet Ma		oon Sumame)		
3	should ind Men s marke umatic	-	19a. Informant's Name/Relationship (Type		19b. Ma	ling Address (Street	and Number or Rural		ity or Town, State, Zip	Code)	
	and 2 lealth a m 27 is		Carol Ann Tolodziecki/ 1	Daughter	24692	Blackiston	e Road, Holly	wool, Mary	land 20636		
ore	of He fitam		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rei	noval from State	20b. Place of Disp cemetery, cr	oosition (Name of ematory or other pla	сө) March	ate 200	. Location - City or To	own, State	
Ĕ	Pages ment of I tant: If it		`4 □Donation 5 □ Other (Specify)	novar nom State		l Cemetery	23, 20		Llywood, Mar	yland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avent, the Medical Examinating the indifferent once.		21. Signature of Funeral Service Licensee	4,	\ <u>\</u>	22. Name and Address that tingley—G	ess of Facility ardiner Funei	ral Home, F	.A.		
			23a. Part1. Enter the disease, or complication	tions that caused	1	'.U. Box 2/U	<ul> <li>Leonardtown</li> </ul>	n. Maryland	20650	Approximate	
b			shock, or heart failure. List only one Immediate Cause (Final	cause on each lin	9.	1		roopinatory arroot,		Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	Wrest	r				
	Examiner		Sequentially list conditions b.	Conce		A. 0	sus.				
-	p #	iner	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	nonsequence of:	1					
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to force	0			·			
68/60,	tificate be executed g physician and as the burial-transit			Due to (or as a	consequence of):						
289	ficate physis the	edical	d.								
ROX			IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of					23d. Date of delive	ery	
	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial transit	by Physician/M	in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	/ 		Month	Day Year	
О	d by the	Phy	9 Unknowń							44.48	
	signer signer		Part II. Other significant conditions contr	buting to death bu	t not resulting in the	underlying cause giv	ren in Part I.		co use contribute to the 2 No 3 Prob		
Hecords,	w require been siç should b	etec									
Ě	he lav e has age 2	Completed				<del></del>		24a. Was an autopsy performed	? prior to co	psy findings available mpletion of cause of	
VItal		a	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26. Place of Death	1 Yes 2	No 1 ☐ Yes	2 □ No	
	Physician: r this certific ral director,	To B	examiner?	pital:	t 2 X ER/Outpatio	ent 3 DOA Oth	er: 4 Nursing Hom		6 □Other (Specif	v)	
n of	<u>a</u> = a		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	28b. Time		y at 28	3d. Describe how i			
S	Attending or death. actor: After by the fune	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2□No				
DIVISION	l or Attencatter death Diractor: In by the	Certification;	4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, s (Specify)	treet, factory, office	28	3f. Location (Stree: City or Town, S	tand Number or Rura tate)	l Route Number,	
	a Hospital or A 124 hours after e Funaral Dira letely filled in b		29a. Certifier 1X Certifying Physic	ian: To the best of	my knowledge, dea	th occurred at the tir	me date and place ar	nd due to the cause	a(s) and manner as s	hated	
	I 4 I 0	edical	(Check only 2 Medical Examine one)	on the basis of and manner stat	examination and/or i	nvestigation, in my o	pinion, death occurred	d at the time, date	and place, and due to	the cause(s)	
	To tha within 2 To the complet	M	29b. Signature and title of certifier			29c. Licens			Date signed (Month,		
			ASha	n		D	H7066	3	2100	0	
			30. Name and address of person who com								
				Mary Med		g Leonardt	town, MD 20	J650 			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 1 2006	Sz. Hegistral	S Signature	٧					

			i icase i	State of Marylar				-	•			
			1 - State Registrar	Otate of Marylar	•	rtificate of			2. No. 0 0 6	10101		
			Decedent's Name (First, Middle, Last)				Douth	2. Date of Death		3. Time of Death		
н	Physici		Leonard Walte	r Todd				March	16 2006	11:00 a M		
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o	r Location of Death	1	4c. County of Dea			
П			1913 Wingate Bish	ops Head Road	đ	Toddville Dorchester						
	Funeral		5. Social Security Number 6. Sex	M OFF		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)		
	Director		214–12–5999 Usual Residence of Decedent	83	Yrs.			July 13	, 1922 Ma	aryland		
	land ow		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits		
7	Many First	tor	MD Dorchest	er		Todd	ville			1 ☐ Yes 2 XNo		
ζ	or 28	irec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	ountry?		
3	death with the Maryland ms 23a or 28e-f show findst be nutified at	Funeral Director	1913 Wingate Bish	ops Head Road			21672		USA			
0	tems	nue		<ol><li>Was Decedent Ever in L Armed Forces?</li></ol>	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
36	s afte	y Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>⊠</b> No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	white		
21215-0036	hour	Completed by	15. Decedent's Educ		16a, Dece	dent's Usual Occup	ation	1	6b. Kind of Business	/Industry		
212	nin 72 nin nin	plet	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of work d)	ing		•		
21	d with	Com	7	Conego (1 to to t)		truck dr	iver		seafood	i		
pu	d oth	Be (	17. Father's Name (First, Middle, Last)					e (First, Middle, M	aiden Sumame)			
yla	ould Men	2	Ovy Todd		-		Mildred					
Maryland	12 sh h and 7 Is rr rreum		19a. Informant's Name/Relationship (Typ	•	1	•			City or Town, State, .	500000		
	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23a or 28e-f show any injury or other treumatic event, the Macical Examination units principled at ODGs.		Lynn Todd  20a, Method of Disposition	daughter 206.	Place of Dispo	sition (Name of			Todoville  Oc. Location - City or	MD 21672 Town, State		
Baltimore,	ages ant of t: If it y or o		1 ⊠Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	emoval from State	cemetery, crei	matory or other plac						
Ħ	artme ortan injur		21. Signatur, (Funeral Service License			2. Name and Addres	al Park 3 ss of Facility T		Cambridge neral Home			
B	Depa Impo any in	l l	If to lem		7	700 Locust	t St., Car					
г			23a. Part Enter the disease, or complice shock, or heart failure. List only one	cations that caused the dear	th. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between		
4	Pnysician		Immediate Cause (Final disease or condition	11-1	EMINI	DIII	111			Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):		ny ule			7		
	LAdillilei		Sequentially list conditions, b.	MULT.	PE	DEWEI	NI Ule	VAS		MENTIPI		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to for as a consec	qualica oi).							
Ć,	execu n and ial-tra	Exar	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):							
1760,	icate be executed physician and s the burial-transit	call	d	·								
89		Medi	IS ESTABLE.									
Вох	death certifica e attending ph id for use as th	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Bc. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	ancy al death 3[	∃Ectopic pregnancy	,		23d. Date of de Month	livery Day Year		
о. П	the at	slci	1 Tyes 2 No	4 Pregnant at time of o	death 5	Other (specify)			Wichter	Day Tour		
<u>α</u>	that the death certifica led by the attending ph detached for use as tt	by Physician/Med	Part II. Other significant conditions cont	tributing to death but not res	sulting in the u	nderiving cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
ds,	es be				3	, ,		1 ☐ Yes	2 € No 3 □ Pi	robably 4 Unknown		
Vital Record	w requir been si should	Completed						24a. Was an	24b, Were at	utopsy findings available		
Re	ysician: The lav is certificate has director, page 2	шс						autopsy perform	prior to death?	completion of cause of		
ta	an: T	a)	25. Was case referred to medical				26. Place of Deatl	1 Yes 2		2 2 1 1 1 0		
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No Ho	ospital: 1 Inpatient 2 I	ER/Outpatier	nt 3 DOA Oth	er: 4 🗌 Nursing Ho	me 5 - Residen	ce 6 □Other (Spe	city)		
n of	ng Ph tter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at	28d. Describe hov				
Sio	Attending r death. ector: Alter by the tune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No					
Division	or At ifter d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci.	ome, farm, str fy)	reet, factory, office		City or Town,	eet and Number or Ri State)	ural Houte Number,		
_	e Hospitel or 24 hours afte E Funerel Dir letely tilled in		29a. Certifier 1 Certifying Physi	ician: To the best of my kno	owledge, deatl	h occurred at the tin	ne, date and place.	and due to the cau	use(s) and manner as	s stated.		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely tilled in by the funeral	edicai	(Check only 2 Medical Examin one)	er: On the basis of examina and manner stated.	ation and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and due	to the cause(s)		
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1///	//	29c. Licens		29	d. Date signed (Mont	h, Day, Year)		
•			Landy 1	( Lan	arg)	D.	31466	-	3/17/0	26		
			30. Name and address of person who con				D		21.604			
			Ludwig Eglseder	r/III, M.D.		Cynwood	Dr., East	con, MD	21601			
	Sta Registr		TORK 17	2000		#OUT						

		ľ	For State Registrar	State of Marylar	•	artment of rtificate of			giene Reg. No:	6 10102			
			Decedent's Name (First, Middle, Last)	)				2. Date of De	f Death 3. Time of Death				
	Physici		Catherine Abell	l Trueblood				March	$12^{Day}$ 200	6 2:00 pM			
	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of	Death	4c. County of Death				
	LAdiiii		Genesis Elder (	Care		LaPla	ta		Charles				
	Funeral		5. Social Security Number 6. Se.		last birthday)	If Under 1 Yea		4 Hrs. 8. Date of Bir	th 9	. Birthplace (State or Foreign			
	Director		579–48–8288 <sup>10</sup>	<sup>□ M 2</sup> XF 87	Yrs.	Months Day:	s Hours	Min. (Month, Da Aug. 11	,1918 I	Mary Land			
	P.		Usual Residence of Decedent										
	rylar	_	10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits			
	Ba-fs	cto	Maryland Charles		Indian					1 Tes 2 No			
	or 28	Jire	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?					
	23a	Funeral Director	4990 Abell Lane			2064			U.S.A.				
	r dez	Tue	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origi Iban, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	American Indian, White, etc.				
98	or It	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 XNo If Yes, Give		1□ Yes 2XXN	o Specify:			White			
8	urel'	d by	3 XWidowed 4 □ Divorced	Year or Dates:	1 10 5								
21215-0036	"nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occi kind of work don DO NOT use retir	e during most of	of working	16b. Kind of Busin	ness/Industry			
12	withir	m du	Elementary/Secondary (0-12)	College (1-4or 5+)		ager	60)		Magazine	2			
2	filed within 72 hours after death with the Maryland Hyglene. ther then "naturel", or Items 23a or 28a-f show ther then "naturel" or Items of the file of an		17. Father's Name (First, Middle, Last)		s Name (First, Middle,		<u> </u>						
anc	2 should be filed within and Mental Hygiene. Is marked other then eumatic event, ILE M.	Be		bell	h J.	Simmons							
Ĕ	d Me d Me nark natic	٦°					ate. Zin Code)						
Maryland	d2s than 7 Is I	19a. Informant's Name/Relationship (Type, Print)  Donna L. Feaganes  Niece  19b. Mailing Address (Street and Number or Rura 5055 Abell Lane, India							-				
	1 and 2 Health em 27								20c. Location - Ci				
Baltimore,	Pages nent of H ant; If its ury or of	1 Daurial 2 Cremation 3 Removal from State						1 16,2006					
ţ	rtmer rtent rtent		* 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens							en, Maryland			
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mantal Hygiene. Importent: If item 27 Is marked other then "naturel", or Items 23a or 28a-f show any figury or other treumatic event, if a MacJosi Exercit er must be notified at Once.		21. Signature of Furieral Service Licens	M006	Funeral	Home, P.A Rd., Indiar	A. n Head. Mo	d. 20640					
	, ž.		23a. Part1. Enter the disease, or composhock, or heart failure. List only o	lications that caused the dea	th. Do not ent	er the mode of dy	ying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Coroni		Don	Entro	2 2	A 2 6	Onset and Death			
	/Medical		resulting in death)	a. Due to (or as a consec		MIGA		1757	1.77 95	N M PS			
	Examiner			ADJAN	JCKOP	142018	JE MM	Carrio	2420	riskera),			
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					xixora).			
	icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	· Denver	721	7				Lixers).			
o,	an ar rrial-t	EX	resulting in death) Last	Due to (or as a consec	quence of);					0			
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9	tifica ng ph as th	a a	AR FOLING	7									
XO	leath certific attending p i for use as i	Physician/M	23b. was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		JEctopic pregnan	nev		23d. Date of				
œ.	deal	sicie	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	4☐ Pregnant at time of of		Other (specify)			Month	Day Year			
P.0	by the	hys	9 🗆 Unknowh	3CI Olikilowii									
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by F	Part II. Dther significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause o	given in Part I.	23e. Did t	ė.	ute to the cause of death?			
Records,	w require been sig should t	ed			·				Yes 212 No 3	☐ Probably 4 ☐Unknown			
S	aw requisite stands	Completed						24a. Was		re autopsy findings available or to completion of cause of			
H	The lav te has	performed? death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No								ith?			
Vital		Bec	25. Was case referred to medical				26. Place o	of Death (Check only o	7-4-1				
>	8 9	examiner?  1   Yes   2   No											
J Of	<b>ਦ</b> € <u>ख</u>		27. Manner of Death	28d. Describe I	how injury occurred								
0	Attending Production of the forest After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	f 28c. Inj W M 1[	Yes 2□N	0					
Division	I or Attendi after death. Director: A I in by the fu	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h	nome, farm, str	reet, factory, offic	е	28f. Location (City or Tox		or Rural Route Number,			
Ö	s afte	Certification:		Danding, etc. (opeci	-7/				/				
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	icai	(Check only 2 Medical Exami	sician: To the best of my kn iner: On the basis of examin	owledge, deat	h occurred at the vestigation, in my	time, date and	place, and due to the occurred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)			
	the hin 2 the I	Medical	one)	and manner stated.					29d. Date signed (				
	To To con	-	29b. Signature and title of certifier	11/11	Sand	Sac. Ficel	nse number	DG	230. Date signed (/	in /			
Ž			hord	4767	V V V V		106	6 1	2/	12/06,			
	1) 17		30. Name and address of person who c	1 . 1		Print)	120	DARE	C Pino	2002			
30. Name and address of person who completed cause of death (Item 23a) Type, Print)  12 (12 (17)							/\ \b \C \D						
	Sta		31. Date filed (Month, Day, Year)  MAR 1 7	32. Registrar's Sign	ALUITO	local .							

			For State Registrar	State of M	faryland /		rtment			ınd M		jiene	06	10103	
- 4	to ta	ΥĒ	Decedent's Name (First, Middle, Late	st)							2. Date of Dea Month	th	Voss	3. Time of Death	
	Physici /Medic		Percell Vene	y							March	6	2006	7:35 P M	
	Examir		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location o	Death		4c. Co	unty of Deat	h	
			Doctor's Comm						nham			Prince George's			
	Funeral		5. Social Security Number 6. S	ex 7. A M 2 ☐ F	ige (In yrs. last b	Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day	, Year)	9. Birtl	hplace (State or Foreign untry)	
	Director	Ŋ.	Usual Residence of Decedent		81	115.					Oct. 14	192	24 Vi	rginia	
	land ow		10a. State 10b. County		10c. City, To	wn or Loc	ation							10d. Inside City Limits	
	Man,	to	Maryland Prince	George's			Land	OVEY						1X Yes 2 No	
	r 288	Director	10e. Street and Number	000180	<u></u>		10f. Zip				1	0g. Citizer	of What Co	untry?	
	h witi		6810 Randolph	St.					2078	34		Uı	nited	States	
	deat	Funeral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13. W	/as Deced	ent of His	panic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		Race - Ame	rican Indian,	
9	or its	/Fu	1 Never Married 2 Married	1 X Yes 2 I	] No		Yes 2			, ruento r	nicari, etc.)	6-	Black, White	a, etc. 1ack	
8	72 hours after death with the Maryland Instural, or itema 23a or 28a-f ahow Ideal Exacultation the medited at	d by	3 Widowed 4 Divorced	Year or Dates	:			110	ороспу.			Sp	ecify: B	Tack	
5	nat	Completed	15. Decedent's Ed (Specify only highest gra		168	(Give k	ent's Usua aind of wor O NOT us	k done di	urina most	of workir	ng	16b. Kind	of Business/	Industry	
12	withir than	mo	Elementary/Secondary (0-12)	College (1-4or	r 5+)	ille. Di		ө <i>гөшгөа)</i> Таі1					D		
d 2	Hygid Hygid ther	e င်	17. Father's Name (First, Middle, Last)							r's Name	(First, Middle,	Maiden Su	Priva	te	
an	ld be ental ked c	To B	David Ven	ey							Lugetia		,	n	
ar y	shound M	_	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailing	Address	(Street a	nd Numbe	r or Rura	/ Route Number				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic avent, the Mudical Exact instant to a rullified at Once.		Brenda Brown/D	anchter		200	-						207		
J.	of He itam		20a. Method of Disposition		comet	of Disposi	ition (Nam atory or ot	e of her place	1	D	ttsvill ate	20c. Locat	ion - City or		
E	Page nent int: if iry of		1 ☐XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State ()	Mary1		-		· .	3/15	706	Che]	Ltenha	m, MD	
a	Departition of the point of the		21. Signature of Funeral Service Licer	S88 A	H_	22.	Name and	d Addres:	s of Facility	St	ewart F				
_	89 2 2 9		John .	Slewar	XIL	,					N.E. W		DC 2	0019	
п			23a. Part1. Inter the disease, or com shock, o heart failure. List only	plications that cause one cause on each	ed the death. Do	not enter	r the mode	of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between	
186	Pnysician	1	Immediate Couse (Final disease or condition	aBlad	der Cano	er								Onset and Death	
8	/Medical Examiner		resulting in death)		s a consequence										
4		<u></u>	Sequentially list conditions,		ia Secon		y to	Hema	turia	1					
	ted nsit	Examine	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury												
	execu n and al-tra	xai	that initiated events resulting in death) Last	cCoag Due to (or a	ulopathy s a consequence	y_ e of):									
8760,	icate be executed physician and s the burial-transit		(	d											
9	certificat nding phy use as th	hysician/Medical		· ·											
Вох	eath certif attanding for use a	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e ol pregnancy 2  Fetal deat	h 2□□	Ectopic pre					23d	. Date of deli	very	
	0 0	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		Other (spe						Month	Day Year	
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Ś	S	by	Part II. Other significant conditions of	ontributing to death	but not resulting	in the und	derlying ca	use give	n in Part I.					the cause of death?	
oro	w requires been sign should be	eted									1 U Ye	es 2∐N	lo 3   Pro	obably 4 Unknown	
of Vital Record	G 8 C	omple						_			24a. Was a autops	iy	prior to c	topsy findings available completion of cause of	
a	n: The licate har.	O				-11-					perform 1 Yes		death?	2□ No	
<del>=</del>	Physician: This certificar at director, p	Be	25. Was case referred to medical examiner?	Hospital:			-	Othe	_		Check only on				
of	Phys r this rai di	: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 XInpat 28a. Date of In	ient 2 ER/O	Time of	3 DO	1	4 🔲 1901		ne 5 Reside			cify)	
OU	th. After funer	tlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D		Injury	м	Sc. Injury Work' 1 □ Y	?` es 2 □ N		.00. 00001100 110	on injury of	acuited.		
Division	or Attending after death. Director: After in by the fune	ertification;	3 Suicide 6 Could not be	28e. Place of Ir	njury - At home, f	arm, stree	et, lactory,				81. Location (St	reet and N	umber or Ru	ral Route Number,	
ā	s afte	Cert	4 Homicide	building, e	atc. (Specify)						City or Town	n, State)			
	To the Hospitel or Al within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier 1 A Certifying Ph	ysician: To the bes	t ol my knowledg	ge, death o	occurred a	t the time	a, date and	place, a	nd due to the ca	ause(s) and	d manner as	stated.	
	the H hin 24 the Fi nplete			and manner s	stated.	11001 1114				II Occurre					
	with Con	Σ	29b. Signature and title of certifier	la Am	Task	MA	? 29c.	License			2		gned (Month	•	
	7				) "			D00	05999	3		Mar	ch 7,	2006	
U	<del></del>		30. Name and address of person who Amirali Amj					Suit	te 25	3 т	aurel, i	MD	20707		
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signature	.a.li		Dul	LE 2)	∍, ⊔	aurel,	LID	20/0/		
	Registr		MAR 1 7 2006	Marie	JE 19	nout !									

DHMH 17 Rev 1/2001

			1 = For State Registrar	State	of Marylar		artment rtificate			and M		giene Reg. No	IIIII	A CONTROLL	104
	Physici		1. Decedent's Name (First, Middle William Khanh	. ,							2. Date of Dea Month March		, 2006		ne of Death
	/Medio Examir		4a. Facility Name (If not institution Suburban Hospi		umber)			Fown, or	Location o	of Death		4c.	County of De Mon	ath tgomer	· · ·
	Funeral Director		5. Social Security Number 586-50-3011	6. Sex 1 M 2 F	7. Age (In yrs. 89		If Under	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da Jan. 10	th y, Yearl	9. Bi		ate or Foreign
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-1 show many injury or other treumatic event, the Madical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montg  10e. Street and Number  4521 East-Wes  11. Marital Status  1 Never Married  15. Decedent  (Specify only highes  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, 1)  Dai Vu  19a. Informant's Name/Relationst	t Highway  12. Was Dec Armed F  1   Yes, G Year or I's Education at grade completed College 2	7, #1102 cedent Ever in U orces? 212 No ive Dates:	16a. Deced	hesda  10f. Zip (  Was Decede f Yes, specification of the control of work of work of the control	208 ent of Hi ffy Cubai No Occupe k done de retired,	spanic Origin, Mexican Specify: ution furing most	r's Name	icity Yes or No- Rican, etc.)	US  16b. Ki  Ci  Maiden	14. Race - Arr Black, Wh Specify: A and of Busines Vil Go Sumame)	1 [] Country?  merican Indian ite, etc.  sian  s/Industry  vernme	
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a important: If item 27 is any injury or other tree		Helen Lee Vu/  20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (St.)  21. Signature of Funeral Service I	3 □Removal from	State	Place of Disponentery, crent of Hear	sition (Name natory or oth ven Cem . Name and rancis	e of her place neter I Addres S J.	y M s of Facility	arch 2006	#1102	20c.Lo Silv l Ho	er Spri	r Town, State	e Maryland
8760,	cate be executed // Medical // Medical Examiner into private in the private in th	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Colo	caused the death aach line.  on Cance (or as a consequence of a conseque	ruence of):	ar the mode	of dying	g, such as o	cardiac oi	r respiratory ar	rest,		Approxi Interval Onset a 1.6 D	Between and Death
O. Box 6	the death certification of the ettending properties as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	tcome of pregna birth 2 □Feta. nant at time of di lown	Ideath 3□	Ectopic pre					1	23d. Date of de Month	olivery Day	Year
Records, P	requires seen sign should be	ompleted by PI	Parl II. Other significant condition  Aspiration Proceedings  Cerebrovascula:	eumonia,	Seizure		nderlying ca	use give	n in Part I.			'es 2[		robably 4	
итал ке	The ate h page	e Comp	25. Was case referred to medical								autop perfor 1 ☐ Yes	sy med? 2 ☐No	prior to death?	completion	of cause of
5	ter this	Certification; To Be	examiner?  1 Yes 257No  27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date (Mon ation	Inpatient 2  of Injury th, Day Year)	ER/Outpatient 28b. Time of Injury		c. Injury Work	r: 4 □ Nur	sing Horr	Check only or ne 5 Resid 8d. Describe h	ence (		əcify)	
<u> </u>	e Hospital or Attendir 124 hours after death. • Funeral Director: Al letely filled in by the fu		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 289. Place build	of Injury - At ho ing, etc. <i>(Specif</i> y	/)					8f. Location (S City or Tow	n, State,	)		lumber,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	one) Z Medical E	Physician: To the examiner: On the c and man	e best of my knowasis of examination stated.	wledge, death tion and/or inv	occurred at estigation, in	t the time n my op	e, date and inion, death	d place, a h occurre	nd due to the d d at the time, d	ause(s) date and	and manner a place, and du	s stated. e to the caus	5 <b>e</b> (\$)
)	To To	Σ	29b. Signature and title of certifier	s W.C	Jaker	1 mg	[	License 0501					e signed <i>(Mon</i> rch 12,		r)
				d Robey,	M.D. 8:	218 Wis	sconsi		venue	, #4	07, Bet	hes	da, MD	20814	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1	7 2006 32.5	legistrar's Signa	ture	medel	7							

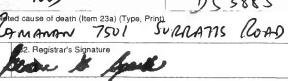
VU, WILLIAM 3/11/06 1350Pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene() [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 15, 2006 **Physician** Year 2:00 Р. м Ellis Woods, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Pay, Year)
June 27, 1942 9. Birthplace (State or Foreign **Funeral** Days 1**⊠** M 2□ F West Virginia 63 Yrs. Director 234-64-0590 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Madical Examiner must be notified at Temple Hills Prince George's 1 XYes 2 No Funeral Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 3930 26th Avenue U.S.A. "naturel", or itema 23a filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, Ite M. dic. 2006. Elementary/Secondary (0-12) College (1-4or 5+) UHaul Company Manager 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellis Woods, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3930 26th Avenue Temple Hills, Maryland 20748 19a. Informant's Name/Relationship (Type, Print) Mrs. Dorothy Mae Woods (Wife) Place of Disposition (Name of Competency Place)

Maryland Veterans Centertery March 24, 216 Cheltenham, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hint Pl. N.E. Washington, DC 20019 Enter the disease, or complications that caused the death. Do not enter or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ANCSR **Physician** OLON /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Stunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Tyes 2X No 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٢ 1 npatient 2 ER/Outpatient 3 DOA this After thi funeral of 28a. D te of Injury (Month, Day Year) 27. Manner of Death Natural 2 Accident 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fr 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) hours after within 24 hours a To the Funeral I 1 Certifying Thysician: To the best of my knowledge disath occurred at the time, date and filene, and dual to the daues(e) and marinar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of cert 29c. License number 1) 23862

State Registrar

31. Date filed (Month, Day, Year)
MAR 2 0 2006



M

CAMAMAN P

		For State Registrar	State of Maryland			nt of H		nd Mer		giene Reg. No.	006	10	106
Physici /Medic		1. Decedent's Name (First, Middle, Las  Jacqueline Fr	ancine Whit	e					Date of Dea Month March	Day 20		6 7	me of Death
Examin Funeral Director		4a. Facility Name (If not institution, give Southern Mary 1 5. Social Security Number 6. Se 577-58-7700	and Hospital	ast birthday)	C	Clint er 1 Year		4 Hrs. 8.	Date of Bird (Month, Da	th y, Year)	9. E	Geo	state or Foreign
Aaryland F ehow		Usual Residence of Decedent  10a. State 10b. County	10c. City	Capi		Hoic	rh+c					10d. Ins	ide City Limits Yes 2 □ No
ith the Marylar or 28a-f ehow	Direct	10e. Street and Number		Capi	10f. Z	ip Code					en of What	-	
ified within 72 hours after death with the Maryland Hygiens. Hygiens therefore in the remaining the most be notified at our, the Madical Examiner must be notified at	by Funeral Director	4324 Will Stre	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:		Was Dec		ispanic Origi in, Mexican, Specify:	in? (Specif Puerto Ric		1	4. Race - A Black, W		
and 2 should be filed within 72 hour feaths and Abantal Hygiene. The train and Abantal Hygiene. Item 27 is marked other than "natural other traumatic event, the Madical E.	Completed t	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation	16a. Dece (Give life.	kind of v DO NOT	vork done i use retired	during most ( 1)	of working			d of Busine	lack ss/Industry	
tally latter to the state of th	To Be Co	17. Father's Name (First, Middle, Last) William W. Add			C	lerk	18. Mother		First, Middle,	, Maiden .	Sumame)		
and 2 should leath and Men n 27 ie marke		19a. Informant's Name/Relationship (1	'husband	4324 Cap	4 Wi	ll S Hei	and Number treet ghts	t . Md	207	43	.,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
t. Page rtment o rtent: if		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	lace of Dispo emetery, cred	matory o	other plac emet	ery		/06	Wasl	ningt		OC
Decrini Impoor		21. Signature of Funeral Service Licen	dwards	2			ss of Facility		_				20746
Physician /Medical Examiner particular and physician and physician and physician site private interesting the private interesting the physician and physicia	Ical Examiner	23a. Pafyf. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence o	uence of):	0		Vasc				2	Interv	oximate and Between t and Death
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quires that quires that an signed b	þ	Part II. Other significant conditions o	ontributing to death but not resi	ulting in the u	underlying	cause giv	en in Part I.	_			se contribut		se of death?
n: The law re icate has ber r, page 2 sho	Completed								24a. Was auto perfo 1 Yes	psy ormed?	24b. Were prior death	to completion?	idings available on of cause of
ysician ysician is certii directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: Inpatient 2	ER/Outpatie	nt 3[]	DOA Oth			5 ☐ Resi		3 □Other (	Specify)	-
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not by	a - 1	28b. Time of Injury	М		yat k? Yes 2 □ N	10	d. Describe				
pital or Att	O	4 Homicide determined	building, etc. (Specify	v)					City or To	wn, State	)	r Rural Rout	e Number,
n 24 hos n 24 ho he Fun pletely f	edicai		nysician: To the best of my kno niner: On the basis of examina and manner stated.										ause(s)
To t withi To t	Σ	29b. Signature and title of certifier	7			29c. Licens	-5 2 6					lonth, Day, \	
Į Ū	ate	30. Name and address of person who michael Sideland		ture	Print)	# [2]	fu.	Ashyfa	- H	020'	7 66		
Regist	rar	TYIAK J 1 ZUU	10 Blower St.	45	194								

			1 - For State of Maryland / Dep	partment of Health and Mertificate of Death		ene) 06	10107
<b>€</b> 2	Physici	_	1. Decedent's Name (First, Middle, Last)  Violet Louise Wiercioch		2. Date of Death March 13	3, Day 2006 Year	3. Time of Death 8:30 P M
	/Medic Examir		4a. Facility Name (If not institution, give street and number)  14511 Colonel's Choice Road	4b. City, Town, or Location of Death Upper Marlboro		4c. County of Death	George's
	Funeral Director		5. Social Security Number  242–22–4293  6. Sex 1  M 2  F	Months Days Hours Min.	8. Date of Birth (Month, Day, Oct 21,	Year) 9. Birth 1922 No.	place (State or Foreign intry) rth Carolina
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I  MD Prince George's Upper	ocation Marlboro			10d. Inside City Limits 1  Yes 2 No
	with the	Direc	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou	intry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "naturs!; or Iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Exertities must be notilitied at <u>once.</u>	by Funeral Director	14511 Colonel s Choice Road  11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ★ No If Yes, Give Year or Dates:	20772 . Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	USA  14. Race - Amer Black, White Specify: Wh	
21215-0036	within 72 hou ene. than "naturs re Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  [Giv   Giv   Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) etail Sales	ring	6b. Kind of Business/li Department	
Maryland 2	uld be filed Mental Hygi irked other itic event.	To Be Co	17. Father's Name (First, Middle, Last)  Reece Carte		e (First, Middle, M	aiden Sumame)	Brooks
Mary	d 2 sho th and I if is mu trauma			ling Address (Street and Number or Rur L Colonel's Choice			
Baltimore,	Pages 1 and 2 ient of Health a nt: If item 27 is ry or other trains		20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition cemetery, or		n 17 2	Oc. Location - City or 1  Clinton,	own, State
Balti	permit. Departminports any inju			22. Name and Address of Facility Le		al Home Cal	
8760,	Physician be executed a stitution of the process of the private of	dicai Examiner	23a. Part. Enter the disease, or comprications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
P.O. Box 6	death certif e attending id for use a	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
	sign d be	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		acco use contribute to	the cause of death?
Vital Records,	The ate h page	Completed			24a. Was an autopsy perform 1 Yes 2	prior to c	opsy findings available ompletion of cause of
Division of Vit	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate hi completely filled in by the funeral director, page	Certification; To Be	25. Was case referred to medical examiner?  1  Yes	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	nce 6 Other (Spec	
Ō	To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place,	and due to the car	use(s) and manner as	stated.
	To the Ho within 24 To the Fu	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	29c. License number		te and place, and due	
	5 7 K 7		I Sterge Drave MA	029353		-1-1	16
	6		30. Name and address of person who completed cause of death (Item 23a) (Type George Graves, MD 5530 Wisconsin				
	Sta Regist		31. Date filed (Month, Day, Year)  MAR 1 6 2006	parle			

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		•	For State Registrar	State of Marylan	d / Depa	artme		ealth and	Mental Hy		_		8 (
	54 By	4	Decedent's Name (First, Middle, Last)						2. Date of De	ath		3. Time of D	eath
	Physicia		Bobby	Bay W	harto	n			March	ı 8 <sup>ay</sup>	2006 Year	1829	М
100	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City	y, Town, or	Location of De	ath	4c.	County of Death		
			Southern Mary				Clint				rince		
	Funeral Director		3/9-/4-/432	7. Age (In yrs. 49	last birthday) Yrs.	Month:	er 1 Year Days	Hours Mi		y, Year) 195	9. Birth Cou Was	place (State or Fintry)	oreign •
	Maryland -f show lind at	tor	Usual Residence of Decedent  10a. State  MD  10b. County  Prince		y, Town or Lo linto							10d. Inside City	
	h with the	Funeral Director	10e. Street and Number 9211 Stuart Lat	ne		10f. Z	ip Code 2073	35			izen of What Cou JSA	intry?	
036	Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show ury gother traumatic avent, Ite Medical Exercises count be notified at ury groups.	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:			edent of His ecify Cubar 2 <sup>M</sup> No		(Specify Yes or No erto Rican, etc.)	•	14. Race - Amer Black, White Specify: B		
Maryland 21215-0036	thin 72 ho e. en "netur	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	kind of v DO NOT	use retired)	uring most of w	vorking		ind of Business/I	ndustry	
21	ygien ygien it, II.	ပ်	12		Di	sab.	Led	10 Mothedo h	lame (First, Middle		lone		
/land	uld be fil Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) unobtainable					Dais	y unobta	aina	able		
Man	nd 2 sho alth and 1 27 is ma r traume		19a. Informant's Name/Relationship (Ty Christpher Maas						Rural Route Numb e Fairfa				0
Baltimore,	ages 1 a ent of Hea nt: If Item	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	(	Place of Disponentery, cre	matory of	other place	m. 3/1	3/06		sh.,D.(		
Baltir	permit. Pa Departmer Important any injury once.		21. Signat red Funeral Service License	02 1					DI FUNEI				
- A			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	A	h. Do not en	ter the m	ode of dying	g, such as card	iac or respiratory a	rrest,		Approximate Interval Betwee Onset and De	een
*	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consec	quence of):	o acq	e / Cir	ncy o	jkus 1)	i Jea	Se	's y	,
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<u>a</u>	uires that the signed by	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the (	underlying	g cause give	en in Part I.	1	obacco (	use contribute to	the cause of de	
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ital		Bec	25. Was case referred to medical examiner?						Death (Check only				
o	ng Phys fer this neral di	은	1 Yes 2 No  27. Manner of Death  Ponatural 5 Pending	fospital: Inpatient 2 [ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	of	28c. Injury Work	at c?	g Home 5 Res 28d. Describe			cify)	
Division	If or Attendiates death.  Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		M treet, fact		Yes 2 □No	28f. Location ( City or To		nd Number or Ru 9)	ral Route Numb	ΘΓ,
_	Hospita 4 hours Funerel	Medical Ce	(Check only 2 Medical Exami	sicien: To the best of my knoner: On the basis of examination	owledge, dea ation and/or in	th occurre	ed at the tim	ne, date and pla pinion, death o	ace, and due to the	cause(s date and	) and manner as d place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner stated.			29c. License	number		29d, Da	ite signed (Monti	n, Day, Year)	
<b>\</b>	¥ ¥ ¥ 8		mal				06	365		O'	3-10-	2006	
•	(		30. Name and address of person who co		m 23a) (Type	, Print)		etc.1	For WAS	h'4 +	tan Mo	70789	,
t.	Sta	ate	Michael Si Walter  31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	4510	N VCS	HIEL	11 7	1)			
	Regist	rar	MAR 15	ZUUD Johnson	10.	9							

		_	1 - For State Registrar	State of	Marylar		artment of <i>rtificate of</i>				giene Reg. No. U	06		09
*	Physici		1. Decedent's Name (First, Middle, L Bonnie Gail	ast) Whited						2. Date of Dea Month March	Day	Year	3. Time of 3:20	Death P M
	/Medio Examir	N	4a. Facifity Name (If not institution, g				4b. City, Town,		of Death	TIGIT .		unty of Death	omery	
	Funeral Director		200-30-4676	Sex 7. 1 ☐ M 2 🔀 F	Age (In yrs.	last birthday) Yrs.	Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da Nov. 2	th y, Υθατ) 8, 1939	9. Birth Cou Pen	olace (State o ntry) nsylvan	
	e Maryland ta-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgot	mery	10c. Ci	ty, Town or Lo							10d. Inside Ci	
	th with th	Funeral Director	10e. Street and Number 3925 Springarder	n Street			10f. Zip Code 2083	2			10g. Citizen	of What Cou USA	ntry?	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department: If term 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	by	1 t. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? ☑No		Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 No			ecify Yes or No Rican, etc.)		Race - Ameri Black, White, ecify: Wh		
Maryland 21215-0036	within 72 hc ene. then "natur ne Medical	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4	or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mos		ing		of Business/In	,	
and 2	Id be filed ental Hygii ked other Ic event, I	To Be Co	17. Father's Name (First, Middle, Las George Urguhart	4		Seni	or Loan	18. Mothe	er's Name	e (First, Middle, Berry		rtgage mame)	!	
Mary	nd 2 shou lith and M 27 is mar r treumat		19a. Informant's Name/Relationship Charles Mahone/			11	ng Address <i>(Stree</i> Springar	t and Numb	er or Rura	al Route Numbe	-		Code)	
Baltimore,	Pages 1 a lent of Hez nt: If Item ry or othe		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		ite (	Place of Dispo cemetery, cre-	osition (Name of matory or other pla ew Cemeter	ace)   1		Date h 17,	20c. Locati	on - City or Ton, V		a
Balti	permit. Departm Imports any inju		21. Signature of Funeral Service Lic	ensee	<u></u>	F	²r\neddad 00 Unive	ess of Gall	Vins Blv	Funeral	1 Home	Inc		
· · · · · · · · · · · · · · · · · · ·	death certificate be executed  Medical  Examiner  Medical  Medical	dicai Examiner	23a. Part1 Enter the disease, or co shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a consec as a consec as a consec	quence of):	VOS (S						Approximate interval Betronset and [	ween
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=	i gita	Certification:	3 Suicide 6 Could not determine	be 28e. Place of	Injury - At h etc. (Special	ome, farm, str	reet, factory, office	1		28f. Location (5 City or Tox	Street and N vn. State)	umber or Rura	al Route Num	ber,
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)	To the I	Σ	29b. Signature and fittle of certifier	$\mathcal{M}$	MD		2 0	se number	316	C .	$\sim 1$	gned (Month,		
10 m	Sta Registr	-	31. Date filed (Month, Day, Year)	completed cause of August 1990 32 Reg	of death (Iter	m 23a) (Type.	Print) Y1WC	hilip	D	rive i	Olne	y, H)	) 20	832

			1 - For State Registrar		State	of Mai	ryland				ealth and I Death	Mental		ne (	)6	0
	Physicia	an	1. Decedent's Name (First, Mi	ddle, Las	t)							2. Date of Month	1	Day	Year	3. Time of Death
	/Medic	al	FOON WU 4a. Fecility Name (If not institu	tion nive	street and n	umber)			4b. City	/. Town. or	Location of Deati	MARCH	10, 2		ty of Death	8:30 P M
f	Examin	er	HOLY CROSS HOSPIT		0,,00, 2,2					ER SPR				MONTGO	MERY	
	Funeral		5. Social Security Number	6. Se		7. Age	(In yrs. I	ast birthday)	If Unde	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of	of Birth		9. Birth	nplace (State or Foreign untry)
	Director		569-43-6658	1[	⊒м 2∰F		87	Yrs.	Morrars	Days	Flours Witt.	OCTOB			CHIN	
	D a		Usual Residence of Decedent 10a. State 10b. Cou	ntv			10c. City	r. Town or Lo	cation							10d. Inside City Limits
	anyla •ho	5		•	,		•									1 ☐ Yes 2 🔏 No
	28a-1	Director	MARYLAND MONTO  10e. Street and Number	OMERY			ROCK	VILLE	10f. Z	ip Code			100	. Citizen of	What Cou	untry?
	Sa or	0	4813 RED FOX ROAL	,						208	52			HINA		
	death ms 2:	Funeral	11. Marital Status		12. Was De	cedent E	ver in U.:	S. 13. \	Nas Dec		ispanic Origin? (S In, Mexican, Puer	pecify Yes		14. Ré	ace - Amer ack, White	ncan Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show eny injury go other treumatic event, it a Madical Examinar must be notified at once, in the Madical Examinar must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ N		Armed F 1 Yes If Yes, G Year or	2. [Ž]No Give				2⊠ No	Specify:	to Alcan, etc	,	i	ity: AS]	
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and and	be find H H H H H H H H H H H H H H H H H H H	Be	17. Father's Name (First, Midd	He, Last)	TYNTIZAT	OLIN					UNKNOWN	1110 (1 1131, 141	idaro, ivie	UNKN		
₹	should be and Mental I amarked o	ဥ	UNKNOWN  19a. Informant's Name/Relati	onship (1	UNKN	OWIN		19b. Mailir	na Addre	ss (Street	and Number or Re	ural Route N	lumber, (			ip Code)
S	d 2 s th an treu		TING WU/DAUGHTER	3Grp ( .	,,,,,						ET. ROCKVI					
ē,	Heal Heal tem		20a. Method of Disposition				20b. P	lace of Dispo	sition (N	ame of		Date				Town, State
9	Page on to a		1 🖾 Burial 2 🗍 Cremati 4 ☐ Donation 5 ☐ Othe			m State			-		ETERY 03/18	3/2006	AD	ELPHI,	MARYL	AND
Baltimore, Maryland	Depermit. I Depertm importe.		21. Signature of Funeral Serv	11	4		1	22 H.	. Name INES-I	and Addre	ss of Facility I FUNERAL	HOME, 1		CDDIN	C MAT	RYLAND 20904
			23a. Part1. Enter the disease shock, or heart failure.	. or comp	olications that	t caused t	the death								G, FIAI	Approximate Interval Between
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Э.	es that the death certifigened by the attending be detached for use a	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		4□Pre 9□ Unk	gnant at t	ime of d			specify) _			_	,	NOTE:	Day
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ds,	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a		Partin. Other signmount com	union3 (	oriting to	douin bu	(1101103	and a contract	i ioony ing	oudso giv	on an an					obably 4 Unknown
Vital Records,	w requir been si should	Completed							-			24a	Was an	241	Were au	topsy findings available
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			25. Was case referred to me	tical							26. Place of De	ath (Check		XI No	1 🗆 Yes	2 □ No
	Physicien: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 ② No		Hospital: 1	☐ Inpatier	nt 2 🖄	ER/Outpatier	nt 3□ i	DOA Oth					ther (Spec	cify)
			27. Manner of Death 1 ☑Natural 5 ☐ Pe		28a. Dat	te of Injury	4	28b. Time o		28c. Injur	y at k?	28d. Des	cribe hov	injury occ	urred	
Ö	Attending r death. ector: After by the funer	atic	2 ☐ Accident inv	estigation	1				М		Yes 2 □ No					
Division	or Attendent after death	ertification:		uld not be termined	280. Pla	ice of Inju ilding, etc.	ry - At ho . (Specif	ome, farm, st y)	reet, fact	ory, office			tion (Stre or Town,		mber or Au	ıral Route Number,
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 🔀 Cert (Check only 2 🗆 Med	ifying Ph cal Exan	niner: On the	the best of anner stat	examina	wledge, deat tion and/or in	h occurre vestigati	ed at the til on, in my o	me, date and plac opinion, death occ	e, and due to	o the cau	use(s) and e and plac	manner as e, and due	s stated. to the cause(s)
	To the within 2. To the complet	Med	29b. Signature and title of ce	tifier		7			7 2	9c. Licens	se number		29	d. Date sign	ned (Monti	h, Day, Year)
			1	//			-2	-		D0021	.033		MAF	RCH 13,	2006	
	V		30. Name and address of per	son who	completed ca	ause of de	ath (Iten	23a) (Type,	Print)				1	,		
			BYOUNG K. LEE, M.						VER S	PRING,	MARYLAND	20906				
6	Sta Regist	ate rar	31. Date filed (Month, Day, Y	ear)	006 32	Registra	r's Signa	ature	arke	9						

		Registrar				Ceni	ificate of	Death			Reg. No.		
Physician	n	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	Day	Year	3. Time of Death
/Medica			nny WEIS		2					March		006	4:40 A
Examine	er	4a. Facility Name (If not institution		number)		4	4b. City, Town,		f Death			ounty of Deat	h
		Lorien Nursing 5. Social Security Number	6. Sex	7 Age (	'In yrs. last bil	irthday)	Colum		24 Hrs. T	9 Date of Bi		oward	holana (State or Forei
uneral rector		139-16-8803	1 M 2 TF		96		Months Days		Min.	8. Date of Bi (Month, Di (ar. 12	аў, Year) 2, 191	0 Pen	hplace (State or Forei untry) nsylvania
-		Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Tow	vn or Loca	ation						10d. Inside City Limit
important. In tail 21 is trained utiler than indicat, or harts 25e or 26e-1 show any injury or other traumatic avent. The Medical Examiner must be notified at once.	Ď	Maryland Howa	rd		Col	Lumbi	<b>.</b>						1 ☐ Yes 2 📉 N
and and	ec -	10e. Street and Number			601	Lumbi	10f. Zip Code				10g. Citizer	n of What Co	untry?
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F	P	Solomon Gin								ia Fel			
		19a. Informant's Name/Relationsh Stanford Rosen		Nephew		•	Old Bal						
0		20a. Method of Disposition 1X□ Burial 2 □ Cremation			20b. Place o	of Dispositi	tion (Name of tory or other pla	1		ate	,	tion - City or	
り		'4 □Donation 5 □Other (St			Beth A	Am Ce	metery	(	3/19	9/06	Mones	ssen,	PA
10.0		21. Signature of Funeral S rvice	Censee			22. N	Name and Address	ess of Facility	AT.7 T	Junara 1	Home		
2 2		23a. Part1. Enterane disease, or	~		_							- Da	20012
				_		25	4 Carro	11 St.	- NW	- Wast	11ne cor	n Du	£UU1£
20		23a. Part1. Enterine disease, or shock, or heart failure. List	complications that	at caused the	e death. Do	not enter	4 Carro the mode of dyi	11 St. ing, such as	cardiac or	r respiratory a	<del>11ng CO</del> I arrest,	n, DC	Approximate Interval Between
ian		Immediate Cause (Final disease or condition	only one cause of	n each line.					oardiac oi	r respiratory a	<del>11ng COI</del> arrest,	n, DC	Approximate
cal		Immediate Cause (Final	a. Con	gesti		diac	4 Carro the mode of dyi Failur		cardiac or	r respiratory a	arrest,	n, DC	Approximate Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Month Year Kenneth Hunter Weaver March 14, 11:45 a M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Montgomery 720 North Belgrade Court Silver Spring 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Follows, Country)
Aug. 24, 1918 Washington, DC If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 110 M 2□ F 577-12-4937 87 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 TNo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 North Belgrade Court 20902 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: Black f Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Elementary/Secondary (0-12) College (1-4or 5+) Government Voucher Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Seldon Weaver Dora Hunter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Prenetta Cannon Weaver/ Wife 720 North Belgrade Court, Silver Spring, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park 20a. Method of Disposition March 20, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2006 Rockville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 nohlu 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-Stage Parkinson's Disease Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underning Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery edent pregnant 3 Ectopic pregnancy Year st 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? itus Ulcer, Stage IV 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28e-f show

r than "natural", or Items 23a or 28e-1 shov the Modical Examiner must be natified at

within 72 hours after

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permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once.

Maryland 21215-0036

Baltimore,

Direct

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Completed

Examine and burial-trar physician Medical Certification; To Be Completed by Physician/Medical use as the attending i detached has Director: After that in by the funeral death.

The law requires that the death certificate be executed

Box 68760,

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Records,

Division of Vital

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	IF FEMALE: 23b. Was ded in the pa 1 ☐ Yes 9 ☐ Unk
	Part II. Other s
1	
	25. Was case

29a. Certifier (Check only one)

autopsy performed? 2**⊠** No 1□ Yes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No

referred to medical examiner? 1 🗌 Yes 2€ No 27. Manner of Death

1X Natural 5 Pending investigation 2 Accident

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Scertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatore and title of certifies

MO

29d. Date signed (Month, Day, Year) March 14, 2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

death (Item 23a) (Type Print)
Forest Glen Road, Silver Spring, MD 20910 30. Name and address of person Robert Gerard, M.D. 1500

State Registrar

filled in by

To the Hospitel or within 24 hours aft To the Funerel Di completely filled in

31. Date filed (Month, Day, Year) 2006



		1 - For State Registrar	State of Mary	land / Depa		lealth and Me Death	ental Hygie	_	10111
Physic /Med	ical	Decedent's Name (First, Middle     Norma Marie Whe	atley		45 City Town		Month	Day Year 13 2004	3. Time of Death
Exam	ner	4a. Facility Name (If not institution, PNINSULA REGION		atal	40. City, Town, o	AUSSUM		4c. County of Death	
Funera Directo		5. Social Security Number 217-30-8148  Usual Residence of Decedent	6. Sex 7. Age (Ir	n yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Y uly 11,	(ear) 9. Birth Co. 1934 Mary	nplace (State or Foreign untry) 1and
Maryland f ehow	tor	10a. State 10b. County  Maryland Dorche		oc. City, Town or Lo		-			10d. Inside City Limits 1 ☐ Yes 2 No
Sor 288	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Co	untry?
23a	Funerai	5007 Reid Road	12. Was Decedent Eve	rin U.S. 13.1	21869	lisnanic Origin? (Spec	fv Yes or No-	USA 14. Race - Ame	ncan Indian
Ind 21215-0036 / C.C.  be filed within 72 hours after death with the Maryland ital Hygiene.  d other then "natural", or items 23a or 28a-f show event, the Madical Exertinal meal be notified at	ğ	1 □ Never Married 2 □ Marri 3 🛣 Widowed 4 □ Divorced	Armed Forces?	· ·	f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	can, etc.)	Black, White	
Maryland 21215-0036 of 2 should be filed within 72 hours aft th and Mental Hygiene. It is merked other then "natural", or tranmatic event, the Madical Exertitional control of the Madical Exertition of	Completed	15. Decedent (Specify onfy highes	s Education t grade completed)	16a. Dece	dent's Usual Occup	pation during most of working d)	16	b. Kind of Business/I	ndustry
d 212 filed withir Hygiene. rther then ont, the M	d mo	Elementary/Secondary (0-12)	College (1-4or 5+)			e Supervis		anufacturi	.ng
and 2	BeC	17. Father's Name (First, Middle, I	.ast)			18. Mother's Name (	First, Middle, Ma	iden Sumame)	
arylance should be formed by the should be former when the should be should	10 E	Norman Gootee				Addie E	skridge		
Maryla d 2 should th and Men 7 is marks traumatic	7	19a. Informant's Name/Relationsh		1		and Number or Rural		-	
C, N 1 and 1 and Heelth mm 27 ther tr	L	Deborah Lowe/Da		P. O. 20b. Place of Dispo		, Sharptow		Land 21861 c. Location - City or "	
Pages nent of I		1 █ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sc	3 □Removal from State	cemetery, crer East New M	arket Cem.	3/17/2	2006 Eas	st New Mar	
Balt permit. Decartr Import		21. Signature of Funeral Service)	icensee Alle	1 Zi	ller fun 6 Main S	eral Home, treet, Eas	P. O. I	Box 207	21631
Physician /Medica Examiner principle	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Myo CA  Due to (or as a co  b. CA D  Dua to (or as a co  c. Due to (or as a co	onsequence of):	INFA	2CT ION			Onset and Death  PAYS
3760, ate be ex hysicien the burial	cai		d						
Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the eltending physicien and complately filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy	y		23d. Date of deli Month	very Day Year
IS, F.	þ	Part II. Other significant condition	ns contributing to death but no	ot resulting in the u	nderlying cause giv	ven in Part I.		cco use contribute to	. 4
Division of Vital Records, to Attending Physician: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be on the control of the	Completed			-			24a. Was an autopsy performe	24b. Were au	topsy findings available ompletion of cause of
Vital Fician: The certificate rector, pag	ပို	25. Was case referred to medical				26. Place of Death	1 Yes 25	No 1 ☐ Yes	2□ No
f Vital Re systician: The list certificate hadirector, page	0 0	examiner?	Hospital:	2 ER/Outpatier	t 3 DOA Oth	or		ce 6 □Other (Spec	cifv)
ion of	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of Injury (Month, Day Ye	28b. Time o	28c. Injur Wor		ld. Describe how		
DIVIS et or Atte s after de ii Directo	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be ned 28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office	28	If. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Divisio  To the Hospitet or Atlandi within 24 hours after death. To the Funeral Director: A complately filled in by the fu	Medical	29a. Certifier Certifyin (Check only one)	g Physician: To the best of m Examiner: On the basis of exa and manner stated	amination and/or in	cocurred at the til vestigation, in my o	me, data and place, an opinion, death occurred	d due to the raun d at the time, date	sa(s) and marrier as and place, and due	stated to the cause(s)
To t To t	×	29b. Signature and the of certifier	lesy, M.	D, Ph.	29c. Licens			3-15-0	
		30. Name and address of person of Tomsz Swier	-KOSZ 100	(Item 23a) (Type,	Print) 0// St.	8689 Salisbu	ry ML	0 2/80/	
S	ate	31. Date filed (Month, Day, Year)	32. Registrar's	oignature	at we.		/		

NORMA MHEATTEY 217-30 8148

			1 - For State Registrar	State of Maryl	and / Dep		Health and	Mental Hygi	ene g. N2 0 0 6	10115
		. 1	Decedent's Name (First, Middle, Las	···			D Catti	2. Date of Death		3. Time of Death
	Physici	an	, , , , , , , , , , , , , , , , , , , ,	Emma Marie	Adolfo			Month Manageria 20	Day Year	м
	/Medio		4a. Facility Name (If not institution, give	street and number)		4b. City Town	or Location of De	March 28	4c. County of Death	2:25P
3	Examir	ier		_						
	Funeral		7302 Bay Front I		rs. last birthda		gemere If Under 24 H	rs. 8. Date of Birth	9 Rinth	ore Co.
	Funeral Director			□M 2∏F 79	Yrs.	Months Days	Hours Mi		Year) Cou	place (State or Foreign ntry) huania
	- <b>4</b> .		Usual Residence of Decedent				1	I CD · Z	J, 1527 1110	aiiia
	ylan		10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
	Mar Med	to	Maryland Balt:	imore		Ed	gemere			1 ☐ Yes 2X No
	r 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	23a c	ai	7302 Bay Front B	Road			212	19	United St	ates
	72 hours after death with the Maryland natural', or Itams 23a or 28e-1 show dital Examinat must be notilised at	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13	. Was Decedent of	Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
ဖွ	or It		1 Never Married 2 Married	1 ☐ Yes 2√ No If Yes, Give		1 ☐ Yes 3√☐ No		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ite
93	ral',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		12.03 92.10	Op00#17.		Specify. WI	.I.C <del>.C</del>
21215-0036	"natur	Completed	15. Decedent's Ed (Specify only highest grad	lucation de <i>completed)</i>	(Giv	edent's Usual Occur e kind of work done	during most of w	rorking 1	16b. Kind of Business/Ir	ndustry
2	within liene.	m ld	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	9d)			
7	77 70 7		0			Homemake	7		Own Hom	ie
ınc	a la b	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M		
7/8	should be ind Menta i marked umatic ev	٦ ٢	Martin Giedra				Elza			
Maryland	d 2 should th and Mer 7 is marke treumatic		19a. Informant's Name/Relationship (7						City or Town, State, Zi, Maryland	
	s 1 and if Health item 27 other t	1 3	Mr. Gary Nejus	(Son)		position (Name of	III KOau			
Ö	0 0 = =		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □	Removal from State	cemetery, ci	ematory or other pla	· 1		20c. Location - City or T	
E			4 ☐ Donation 5 ☐ Other (Specify	1		of Faith				, Maryland
Baltimore,	permit. Pag Department Important: any njury c		21. Signature Funeral Service Licen		1	22. Name and Addr Duda-Ruck	ess of Facility Funeral	Home of I	Dundalk, In	C.
_	au z e u		W/Ogon (	- las					ryland 21	
			23a. Part1. Enter the Usease, or comp shock, or hear failure. List only	one cause on each line.						Approximate Interval Between Onset and Death
	Physician	g 3	Immediate Cause (Final disease or condition	lardy	i by	ry. Keen				mineral.
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):	111	/	1	20	W.
	LAGIIIIIIEI		Sequentially list conditions	b. Hyperten	on 1	Hiero sil	eop 4	order Vos	ula Dijas	logen
	D #	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due/16 (or as a con	sequence of):					16
	and tran	carr	that initiated events resulting in death) Last	c. Due to (or as a con	acqueres of					
760,	be executed siclan and burial-transit	a E		Due to (or as a con	saquence or).					
87	m × 6	dicai		d					-	
x 68	The law requires that the death certificat tie has been signed by the ettending phy agge 2 should be detached for use as th	Physician/Med	IF FEMALE:	220 If you cutesma of are						
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre	etal death 3	□Ectopic pregnanc	ey .		23d. Date of deliv Month	ery Day Year
0.	at the de by the e	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time 9☐Unknown	of death 5	Other (specify)				
Д.	that the ed by detac		Part II. Other significant conditions of	patributing to death but not	resulting in the	underking cause o	ven in Part I	23e Did tob	acco use contribute to	the cause of death?
of Vital Records,	signe signe	by	Non lusuli Dy	A	x 65 M		VOITHIT ATTI.			bably 4 ∏Unknown
0	w requir been si should	etec	- may	Conon, Sia	K-V7 /	cours				
ec	e law has b	Completed	*					24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
=		ပ်						perform 1 ☐ Yes 2	ned? death? □No 1 □ Yes	2000
/ita	Physician: 'this certifica' ral director, p	Be	25. Was case referred to medical examiner?					eath (Check only one	)	
5	ys dis	မ	To res 20 No	Hospital: 1   Inpatient		BIN SELDOA	her: 4 Nursing		nce 6 Other (Speci	fy)
Ē		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time Injury	Wo	ry at ork?	28d. Describe hor	w injury occurred	
sio	E # 5 0	cati	2 Accident investigation				Yes 2 No			
Division	after death after death Director:	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, s ecify)	street, factory, office		28f. Location (Str. City or Town,	eet and Number or Rur , State)	al Route Number,
Ω	Itel or rel D	O						1		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical	(Check only 2 Medical Exam	ysinian: To the best of my liner: On the basis of exam	nination and/or	investigation, in my	opinion, death oc	curred at the time, da	ite and place, and due t	o the cause(s)
	the the mplei	Med	one) 29b. Signature and tells of certifier	and manner stated.		20e Liene	an number	-100	ld Data sissed (Month	Oay Vaari
	2 × 1 × 0		250. Signature and the or certifier	1/2		Zac. Licen	ao Humber	_   29	2 -	Day, real)
•	A		· cana	den	n	1 D	10551		Morh 30,	2006
	5		30. Name and address of person who o	completed cause of death (	Item 23a) (Type	e, Print)	Anit	20 1	110	21219
L	C 100		31. Date filed (Month, Day, Year)	Jenni in	5 /	366 Novice	- 1.0W	100 /10	1 trus	MI)
	Sta Registr	_		006 Delve	J. A				•	Day, Year)  2006  MD 21219
150.00	3 N N		AFRUJA	UUU MARKET						

			1- For State of Maryland / Dep	partment of Health and Nertificate of Death		giene Reg. NG. 005	0116
Т	Dhusisi		Decedent's Name (First, Middle, Last)		2. Date of De		3. Time of Death
	Physici /Medio		Brittania P. Ammann		March	29, 2006	9:22 P M
1	Examin	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
_	Funeral		6118 Walton Ave.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Camp Springs  (i) If Under 1 Year If Under 24 Hrs.	8. Date of Birt (Month, Da	Prince Ge	
	Director		579 14 2741 1□M 2√F 95 Yrs.	Months Days Hours Min.	June 16	y, Year) Co 1910 Mary	nplace (State or Foreign untry) 'land
	pug *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits
	Maryla f eho	ō	Maryland Prince George's Camp S				1 ☐ Yes 2/CNo
	128a	Directo	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	
	th with		6118 Walton Ave	20746		United S	tates
950	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Deperment of Heatile and Menalle Hygiene. Deperment: If term 27 is marked other then "natural" or items 23a or 28a-f show any Injury or other traumatic event, II.a Medical Exactical most be notified at DDGs.	by Funeral	11. Marital Status  1 Never Married 2 Marned    12. Was Decedent Ever in U.S. Amed Forces?   1 Yes 2 No   1 Yes, Give And   1 Yes, Give And   1 Yes of the state	Was Decedent of Hispanic Origin? (Sp. tf Yes, specify Cuban, Mexican, Puerto     □ Yes	pecify Yes or No Rican, etc.)		
2-003g	2 hou	ted	15. Decedent's Education 16a. Dec	edent's Usual Occupation		16b. Kind of Business/	Industry
ž	ithin 7	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	re kind of work done during most of work  DO NOT use retired)	ang	Own Home	
7	lled w dygier her th		17. Father's Name (First, Middle, Last)	emaker	a (Ciash beindalla	Maiden Sumame)	
yland	12 should be filed within h and Mental Hygiene. 7 is marked other then "r traumatic event, the Me.	To Be	Eugene Calvert Peters	Maria	a Ellen	Taylor	
, Mar	and 2 shealth and m 27 is n		Shirley Eppard (Daughter) 510	iling Address (Street and Number or Run 03 Armand Ave, Camp	Springs	s, MD 20746	
20	Peges 1 nent of H int: If Ite iry or otl		Tendinal 2 Dolamation 3 Dramoval non State   Worth and	position (Name of ematory or other place) pril 1, ton National Cemeto	<sup>D</sup> <b>2</b> 006	20c. Location - City or	
	it. Pe ortmer ortant ojury			22. Name and Address of Facility $\operatorname{Lee}$	-	Suitland, M	
D D	Depertment of the property of			Alexandria Ferry Ro		The second secon	
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.				Approximate Interval Between
F	Physician		1 64 6 65	scular accider	+		Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	o cooker to co	,		
	LAdimine	<u>.</u>	Sequentially list conditions, if any, leading to immediate				
/	uted I Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
, -	execunancial-tra	Exa	that initiated events resulting in death) Last c				
00/0	ite be iysicie na bur	Ical	d.				
ō	certificate nding phys	10	IF FEMALE:				
ň	death e atter	Physician/Me	1 Yes 2 No 4 Pregnant at time of death	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	very Day Year
٦.	requires that the seen signed by th hould be detache	Phy	9 DONKHOWN		00- 014		
Ś	signer	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	obacco use contribute to Yes 2⊉Ño 3⊟Pr	the cause of death?
ecoras,	v requ	Completed	- HYPENTON				
	has has	E P			24a. Was autor perfo	rmed? death?	topsy findings available completion of cause of
Vital	Physician: The this certificate har al director, page	O I	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes	2 No 1 Yes	200 No
<u> </u>	nysici nis cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	Othor		dence 6 Other (Spec	cify)
0 =	ing Pt Viter th Ineral		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time (Injury) 1 Natural 1 Natural 1 Natural 2 Natura		28d. Describe I	how injury occurred	
<u> </u>	ttendi Jeath. tor: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	204 1 1	0	
DIVISION	I or A efter Direc	ertification;	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	City or Tou	Street and Number or Ru wn, State)	iral Houle Number,
	To the Hospital or Attending Physician: To the Funeral Director: After this certifica completely filled in by the funeral director; I	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To th Withir To th comp	¥.	29b. Signature and title of certifier	29c. License number		29d. Date signed (Monti	n, Day, Year)
			A. Kahuway	D00520	199	3/30/	6
	(.		30. Name and add ss of person who completed cause of death (Item 23a) (Type	•		· ·	
	4		Ali Rahimian, MD 7501 Surratts R  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Md. 2073	35	8.
	Sta Registi		APR 0 3 2006	1 at .			
DHN	/IH 17 Rev 1/2	-	APR 0 3 2006				-
				SINAL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 3:16 AM MARCH 30 2006 ALICE LEE ALEXANDER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M Yrs. 212-22-9365 92 Jan.15,1914 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or items 23s or 28s-f show the Medical Examiner must be notified at Yes 2□No Directo Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 W. University Pky. Apt.169 21210 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 WNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White ρ 3 Widowed 4 Divorced "naturel" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private School permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygiel
Importent: If item 27 is marked other It
eny injury or other traumatic event, Ita
once. +5 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Allen Lee Rebecca Diffenderffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bonnie Lee Alexander (Daughter) 500 W. University Pky. Apt. 169 Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State 4/4/06 Pikesville Mryland 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery Funeral Service License 22 Name and address of Facility
Mitchell-Wiedefeld F.H. Inc. 21. Signature 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cabe on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA CARDIAC **Physician** HOURS /Medical Due to (or as a consequence of): Examiner ACIDOSIS 2 HOURS LACTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ANEMIA 2 HOURS or Attending Physician: The law requires that the death certificate be executed use as the burial-transit MICROCYTIC that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical signed by the attending I be detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 21 No 1 ☐ Yes Division of Vital : After this certifical funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Unpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation 1 Natural within 24 hours after death.

To the Funerel Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946F13 MARCH 30, 2006 engen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL MENGAR ICAVITA Associal s 32 Registrar's Signature 31. Date filed (Month State 2006 Carren . Registrar

		4	For State Registrar	State of Marylar	•		t of Health a e <i>of Death</i>			giene Reg. NG. (	06	
	Physici	an	Decedent's Name (First, Middle, Lass Shirley Elizabet	eth Barnes					2. Date of Dea Month <b>March</b>	Day	06 Year	3. Time of Death 1:28am M
	/Medic Examin		4a. Facility Name (If not institution, give Southern Marylan			C1	Town, or Location inton			Pri	nce Ge	orges
	Funeral Director		5. Social Security Number 6. S 066-34-7308 1  Usual Residence of Decedent	ex 7. Age ( <i>In yrs</i> . □ M 2 <b>/</b> 5 F 63	last birthday) Yrs.	Months	1 Year If Under Days Hours	Min.	8. Date of Birtl (Month, Da) 12/16/	v, Year)	Cou	place (State or Foreign untry) hington DC
	Maryland -1 show lied at		10a. State 10b. County	Georges 10c. Ci	ity, Town or L							10d. Inside City Limits 1 ☐ Yes 2 No
	with the	Direc	10e. Street and Number 9211 Stuart Lane	2		10f. Zip	Code 20735	5		10g. Citize	n of What Cou	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show simportant: If item 27 is marked other then the notified at any injury or other traumatic event, the Modical Exactinar matter and lifed at ance.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in L Armed Forces? 1 Yes 2000 If Yes, Give Year or Dates:	J.S. 13.	Was Dece If Yes, spe 1 \( \text{Yes} \)	dent of Hispanic Or city Cuban, Mexica 2 No Specify		cify Yes or No- Rican, etc.)		. Race - Amer Black, White pecify: B1	
Maryland 21215-0036	within 72 hou ane. then "nature e Medical E	mpleted	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)	(Give	edent's Usu e kind of wo DO NOT u	al Occupation rk done during mos se retired)  Clerk	st of workir			of Business/I	•
land 2	ild be filed the formal Hygierked other fice event, It	To Be Co	17. Father's Name (First, Middle, Last, Willie Cleo Till	)	1		18. Moth		(First, Middle, Fergus	Maiden S		
Mary	nd 2 shoulth and M		19a. Informant's Name/Relationship ( Marian Delores Do	Type, Print) ortch / Sister	19b. Mail 1624	ing Address Foun	(Street and Numb	er or Aura eet, I	Route Numbe	or, City or Tount	NC 278	ip Code) 01
Baltimore,	Pages 1 a lent of Hea nt: If itam iry or othe		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special	Removal from State Ga	Place of Disp cemetery, cre rdens	osition (Na omatory or o of Ge	ne of other place) Lhsemane		ate 2006		ation - City or T	
Balti	permit. Departm Importa sny inju		21. Signaturi of Juneral Service Lice	nsee	2	Char	nd Address of Facil les L. Stev East Fort	<i>r</i> ens Fl	neral Ho altimore	me Inc MD 212	2. 230	
-	Physician /Medical		23a. Part1. Enter the disease or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	MYOC	nter the mod	de of dying, such as	s cardiac o	r respiratory ar	rrest,		Approximate Interval Between Onset and Death HOUR S
2	Examiner	er	Sequentially list conditions, if any, leading to immediate	b	Coro	nary	arteri	al	didea	se		YEARS
8760,	cate be executed by sicien and the burial-transit	ilcal Examine	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c		(perte	ension					YEARS
P.O. Box 6	The law requires that the death certific attending p has been signed by the attending p page 2 should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3	□Ectopic p □ Other (s				23	d. Date of deli Month	ivery Day Y <i>e</i> ar
rds, P	w requires that been signed t should be det	þ	Part II. Other significant conditions - Congestive - End Stage	contributing to death but not re	esulting in the	underlying	cause given in Part	I.				the cause of death? obably 4 Dunknown
Reco	The law re ate has bee page 2 sho	Completed	- End stage - Dementia	renal did	relow	1 de	alysis	whation	24a. Was autor perfo		prior to death?	stopsy findings available completion of cause of
f Vital	ysicien: is certifical	To Be C	25. Was case referred to medical examiner? 1 □ Yes 2 No	Hospital: 1 1 Inpatient 2	□ ER/Outpatie	ent 3 D			( <i>Check only o</i>		□Other (Spec	cify)
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this centification completely filled in by the funeral director.	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not I determined	De 28a Place of Injuny . At	28b. Time Injury home, farm, s	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ y, office	□No	28d. Describe 28f. Location ( City or To	Street and		ural Route Number,
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my kr miner: On the basis of examinand manner stated.	nowledge, dea	ath occurred investigation	l at the time, date and in my opinion, de	and place, and place, a	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	s stated. a to the cause(s)
)	To the within To the comple	Me	29b. Signature and title of certifier  R. Sindheuml	,			c. License number	614		ŝ	signed (Monti	
1	5		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	e, Print)	RAVINDER INTON, 1	nAR:	VDHWAN XLAND	1		
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign								

			1 - For State Ragistrar	State of Maryland	I / Department of I Certificate of		-	ene 0 0 6	10119
	Dhoolai		1. Decedent's Name (First, Middle, La	ist)	2		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Charles		Bockner,	Senior	March	30 2006	13:49 PM
	Examin		4a. Facility Name (If not institution, gire			or Location of Death		4c. County of Death	
			Johns Hopkins E	Bayview Medical		move City	Y	Baltimor	e City
	Funeral			Sex 7. Age (In yrs. la	Months Days		8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign
	Director		212-18-9813	85	Yrs.		May 24,		yland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City.	Town or Location				10d. Inside City Limits
	Aaryl ede	ō	Mararal and Ba	ltimore		undalk			1 ☐ Yes 2 ☑ No
	28e-	ect	Maryland Ba	TCIMOLE	10f. Zip Code	undark	100	. Citizen of What Cou	ntn/2
	with be or		6901 Brentwoo	d Ave.	10.1.24	21222		nited Stat	•
	72 hours after deeth with the Maryland naturel', or Heme 23e or 28e-f ehow disal Examinational be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	5. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe	ocify Yes or No-	14. Race - Ameri	can Indian.
(0	r ker	F	1 ☐ Never Married 2 ☐ Married	Armed Forces?  1/TVes 2 PNo If Yes, Give			Rican, etc.)	Black, White,	etc.
8	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
2-0	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Decedent's Usual Occup (Give kind of work done	pation	16	b. Kind of Business/Ir	dustry
21	within ene.	n pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire	nd)			- 311
21	filed wi Hygien other th	Completed	9 Years		Chief Eng			Commercial	Credit
P	d oth	Be	17. Father's Name (First, Middle, Las	•		l .	(First, Middle, Ma May Cave		
yla	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Ma	မ	Frederick Bocks						
Maryland 21215-0036	2 sh and terr	1	19a. Informant's Name/Relationship Mrs. Sarah C. BC		19b. Mailing Address (Street 6901 Brentwo	tand Number or Rura ood Ave.	Dundalk.	City or Town, State, Zi, Maryland	21222
	pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other thene, naturel; or iteme 23e or 28e-f ehow amp njury or other traumatic event, the Madical Examinar must be notified at 90.59.					The second second			
Baltimore,	t of the transfer or of	-	20a. Method of Disposition  ™XBurial 2 ☐ Cremation 3 [	0.00	ace of Disposition (Name of metery, crematory or other pla	ice)	Date 20	c. Location - City or T	own, State
Ë	ment tent:		4 □ Donation 5 □ Other (Speci	1000	rison Forest		4/5/2006	Owings M	ills, MD
Sal	Departiment of the post of the		21. Signature of Funeral Service Line	0500	22. Name and Addre Duda-Ruck	ess of Facility Funeral H	Iome of D	undalk, In	C.
	4034 Q		May (III)	Lavo y	7922 Wise	Ave. Du	ndalk, Ma	ryland 2	1222
н			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the acath.  one cause on each line.	. Do not enter the mode of dyi	ng, such as cardiac o	or respiratory arrest	ι,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a_ aspirati	ion pneumo	pinc			2 days
1	/Medical Examiner		resulting in death)	Due to (or as a consequent	·				
	Examine:	L	Sequentially list conditions,	0	ner's disea	se			wknow 1
	ed isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequent	ence or):				
	Physicien: The law requires thet the deeth certificate be executed this certificate has been signed by the ettending physicien and rall director, pege 2 should be deteched for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ence of):				
8760,	be e	icai E							
387	phys the	dic	•	_ d					
9 X	ding se as	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregnan	ncv			201 5 1 115	
Вох	etten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnance	y		23d. Date of deliv Month	Day Year
P.O.	the d y the ched	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	an old outer (specify)				
	res thet the de igned by the e be deteched f	4	Part II. Other significant conditions	contributing to death but not resul	Iting in the underlying cause gr	ven in Part I.	23e. Did toba	cco use contribute to	he cause of death?
sp.	uires sigr Id be	d by	lower q.i. b	leeding due t	o diverticu	10515	1 ☐ Yes	2 18No 3 □ Pro	bably 4 Dunknown
Records,	w require been si should t	Completed					24a. Was an	24h Ware aut	opsy findings available
Re	he la e has	Ę					autopsy performe	prior to co	empletion of cause of
Vital	n: T ificate or. pe	e C	25. Was case referred to medical			00 01	1  Yes 2	No 1 ☐ Yes	2 No
Ē	s cert irect	To B	examiner?	Hospital: 1 12 Inpatient 2 1	ER/Outpatient 3 DOA	hor	(Check only one)	ce 6 ☐Other (Speci	4.1
o	JPhy or this eral c		27. Manner of Death	<del></del>	28b. Time of 28c. Inju	· · · · · · · · · · · · · · · · · · ·	28d. Describe how		(9)
Division	Attending r death. ector: After by the fune	ţ	1 Panatural 5 Pending 2 Accident investigation			rk? ]Yes 2 □No			
N.	Atter r dea octor	HC	3 ☐ Suicide 6 ☐ Could not I	286. Place of injury - At nor	me, farm, street, factory, office		28f. Location (Stree	et and Number or Rur	al Route Number.
Ö	al or alte	Certification:	4 Homicide	building, etc. (Specify)			City or Town, :	State)	
	nours nore nere		29a. Certifier 1 Certifying P	hysician: To the best of my know	viedge, death occurred at the ti	me, date and place,	and due to the caus	se(s) and manner as :	stated.
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	(Check only 2 Medical Exa	miner: On the basis of examinati and manner stated.	on and/or investigation, in my	opinion, death occurr	ed at the time, date	and place, and due t	o the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	2	29c. Licen:	se number	29d	. Date signed (Month,	Day, Year)
	1		1 John Schoa	Garl MD PhD	RE	ES-000	~	brich 30,	2006
6	1/		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)				
9	. ~		John Schoenkard HDF	70, Johns Hopkins 1	Hospital, Tower 110	Poctos Lour	ge, 600 NU	Volfest, Balt	imore MO 2128
Ţ.	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signati					

			1 - For State Registrar	State of M	arylan				ealth a Death		lental H	ygien Reg. N	200		A CHARLES OF THE PARTY OF THE P	20
			Decedent's Name (First, Middle, Last)	2.74							2. Date of I	Death	ay	Year	3. Time	of Death
	Physicia /Medic		Mil	dred E.	Barsk	αi	,				March	30	, 2	006	4:30	A M
	Examin		4a. Facility Name (If not institution, give s				· ·		Location of	of Death		4	-	of Death		
H			Bethesda Health ar			er last birthday)		hesd	a. If Under:	24 Hrs.	8 Date of F	Birth		gome		or Foreign
	Funeral Director			M 20 F	88	Yrs.	Months		Hours	Min.	8. Date of E (Month, I Nov.	Day, Yea 7, 1	917	Penr	olace (State ntry) 1Sy1va	nia
	pug *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty. Town or Lo	ocation								10d. Inside (	City Limits
	Maryla f eho	lor	Maryland Montgome	rv		thesda										s 2 No
	r 28a-	Funeral Director	10e. Street and Number	L y	Бе	chesua		p Code				10g. C	Citizen of V	What Cou	ntry?	
	th with	al D	5721 Grosvenor La	ne				20814	4				Unit	ed St	ates	
	r dea	ner	Tr. Marian States	12. Was Decedent Armed Forces	?	l.S. 13.	Was Dec If Yes, sp	edent of H edify Cuba	ispanic Ori in, Mexican	gin? (Spe	ecify Yes or I Rican, etc.)	No-		ce - Ameri ck, White,	can Indian, etc.	
36	within 72 hours after death with the Maryland lane. than "natural", or items 23a or 28a-f ehow than Madical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XX If Yes, Give Year or Dates:	No		1 🗆 Yes	2 <b>K</b> ) No	Specify:				Specif	y: Wh	nite	
ခို	2 hou atura cal E	ted	15. Decedent's Educ	cation		16a. Dece	dent's Us	ual Occup	ation during mos	t of work	ina	16b.	Kind of B	usiness/Ir	dustry	
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT	use retired	)	t or worki	ng					
2	led wi lygian her th		9				Home	make		ar'a Nama	e (First, Midd	llo Maide		Home	5	
and	d be find H	Be	17. Father's Name (First, Middle, Last)  Moses E. Fain						Emma			ne, maior	on Suman	110)		
Ž	should nd Me mark matic	၉	19a. Informant's Name/Relationship (Ty)	oe, Print)		19b. Maili	ng Addre	s (Street			Al Route Nun	nber, City	or Town,	, State, Zij	Code)	
S	etth ar 27 is er trau		Joan B. Gordon / D	aughter		1649	Harv	ard S	Stree	t, N.	W., Wa	shin	gton,	D.C.	200	09
or G	es 1 a of He of He f Item r oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ R	amoval from State	1 0	Place of Disponentery, cre-	matory or	other plac	e)	Apri	late 1,	20c.	Location -	- City or T	own, State	
Ĕ	Pag ment tent: t		4 □ Donation 5 □ Other (Specify)			Cremat				20	06	Ве	thes	da,	Mary1a	and
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hyglane Department of Heelth and Mental Hyglane Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show importent if Item 27 is marked other than "natural", or Items 23a or 28a-f show importent it aumatic event. Ite Medical Exam are must be notified at once.		21. Signature of Funeral Selvice License	7	M014	Ro Ro	bert	A. Pur	ss of Facilit nphrey in Aver	Fune	ral Hom Bethesd	e/Bet a, Ma	hesda ryland	-Chevy	Chase	, Inc.
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that cause le cause on each	ed the deat line.	th. Do not en	ter the mo	de of dyin	g, such as	cardiac o	or respiratory	arrest,			Approxima Interval Be Onset and	etween
/	Physician		Immediate Cause (Final disease or condition resulting in death)	Conges			Fail	ure							5 Day	
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8760,	cate be executed oblysicien and the burial-transit	EX	resulting in death) Last	Due to (or a	s a consec	quence of):										
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Box	nding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcom			¬=					l.	23d. Da	ate of deliv	ery	
m C	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as:	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1□Live birth 4□Pregnant a 9□Unknown			Other (	pregnancy specify)				-	Mo	onth	Day	Year
P.0	that the	f.	Part II. Other significant conditions con	tributing to death	but not res	sulting in the u	ınderlying	cause giv	en in Part I	l.	23e. Di	d tobacc	o use con	tribute to	he cause of	death?
ďs,	tuires n sign ald be	d b	Cerebrovascul	ar Accid	ent						1(	☐ Yes	2 <b>X</b> No	3 ☐ Pro	bably 4	]Unknown
Vital Record	aw rec	plete									24a. W	as an topsy	24b.	Were aut	opsy finding ompletion of	s available
ž		E									pe 1 □ Yes	rformed?	?	death?		Cause of
ita	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?					100		e of Deat	h (Check onl	y one)				
<u>o</u>	ding Physicien: h. After this certific funeral director.	5	1 ☐ Yes 2 💢 No  27. Manner of Death			ER/Outpatie			4 14		me 5 Re 28d. Describ				fy)	
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Division of	or Atten ifter deal Director: in by the	ertification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At h etc. (Speci		reet, facto	ry, office			28f. Location City or	(Street Town, Sta		ber or Rur	al Route Nu	mber,
	Hospital 4 hours e Funerel I ely filled	edical Ce	29a. Certifier 1tg Certifying Phys (Check only 2 Medical Exami	sician: To the bes	t of my kno	owledge, deat	th occurre	d at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the	ne cause	(s) and m	anner as	stated.	e(s)
	To the h within 2 To the F complete	Med	one) 29b. Signature and title of certifier	and manner s		2		9c. Licens				,			Day, Year)	
	5 7 8 5 8		>-/_>		F	S			)53528	8			_		2006	
	3		30. Name and address of person who co	m 23a) (Type	, Print)											
	9		Daphna Henkin,		,	norefie	· ·	oad,	Whea	ton,	Mary1	and	2090	02		
	Sta		31. Date filed (Month, Day, Yeár)		trar's Sign	ature	W 20									

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH Year **Physician** James Matthew Caffrey 1:25 P M 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Ceci1 Union Hospital **Elkton** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/29/36 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10**X**M 2□ F Months Days Hours Min 152-26-0149 69 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10a State 10h Counts other traumatic avant, the Mudical Examinar must be multiled at 1 ¥Yes 2 □ No SC Director Horry North Myrtle Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29582 1222 Pine Valley Road USA or Itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bell Lab. Director 12 Δ 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental F Matthew Caffrey Edythe Benoit 2 permit. Pages 1 and 2 sh.
Department of Health and Important: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy Caffrey / Son 66 Kensington RD Basking Ridge NJ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Semoval from State Somerset Hills Crematory 3/22/06 Basking Ridge, NJ \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 East Fort Ave Baltimore MD 21230 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disea. c. com shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final OP **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of Examiner burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: ISO S 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attanding Pl 24 hours after death. e Funeral Director: After ti Certification: 5 Pending investigation 1 Natural 1 Tes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature certifie MARY 17, 2006 M

Registrar

Staté

ASHOR

31. Date filed (Month, Day, Y

MARKEL CARRE

106

STREET

Bow

GLKTON, MD 21921

of person who completed cause of death (Item 23a) (Type, Print)

MANGENTER CUE

2006

Year)

MD

327 Registrar's Signature

			Please 1	ype or Print State of Ma						•		Legible.	
	^. · · ·		State Registrar  1. Decedent's Name (First, Middle, Last,	1	С	ertificate	e of L	Death		2. Date of D	Reg. No	0.06	0   2 3 3. Time of Death
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	/Medic Examin	- 1	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of	Death		4c.	County of Death	
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Ŷ.	Funeral Director		212-20-3333	м 254	77 Yrs.	Months		Hours	Min.	03/26	5/19:	29	place (State or Foreign intry) PA
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
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	fler de	Funeral	11. Marital Status 1 ☐ Never Married 2 ★ Married	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 ▼ No		If Yes, spec	rfy Cuba	in, Mexican,	Puerto I	Rican, etc.)		Black, White	
5-0036	ours a	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working										Specify: Wh	ite
က်	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28a-f ehow ha Mudeal Exemiter must be notified at										16b. Kir	nd of Business/I	ndustry
2121	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow or other traumatic event, the Mudical Examiner must be notified at	dmc	Elementary/Secondary (0-12)	College (1-4or 5+	)	. DO NOT us Iomema					Ow	n Home	
	illed Hygi other	BeC	17. Father's Name (First, Middle, Last)		-				's Name	(First, Middle			
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Maryland	2 sho and I is ma	1 0	19a. Informant's Name/Relationship (T)	_								Town, State, Z.	
	1 and Health em 27	l į	Richard Clocker 20a. Method of DispositionEntom	·	20b. Place of Dis	100		1 Av		e, Pa:	_	na, MD	
altimore,	permit. Pages Department of I Important: If It any injury or o once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ F		Glen H	rematory or of	ther plac		04/	24/06			nie, MD
	mit. Portan cortan injur	1	21. Signature of Emeral Service Licens	98	Glen								Home, PA
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Box 68760	death certificate be e ettending physicia of for use as the bu	N/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o		3 □Ectopic pr	eanancy				2	23d. Date of deli	•
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Division of Vital Records,	uires signe	d by	diavalie	dystu	nation	1				1	Yes 2[	□No 3□Pro	bably 4 nknown
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á	s after st Dire	Certification:	4  Homicide determined	building, etc.	(Specify)					City or 1	own, State,	,	
	To the Hospitel or Attendi within 24 hours after death. To the Funeret Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exemi	sician: To the best of ner: On the basis of and many r stat	examination and/o	eath occurred r investigation,	at the tin , in my o	ne, date and pinion, deat	d place, a h occurr	and due to the ed at the time	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
ŀ	within 2 To the	W	29b. Signature and title scentifier	Hen	Agus	290	. Licens	e number ) $\mathcal{M}$	438		Mar.	e signed (Monti Wh. 31	, Day, Year)
4	ITY		30. Name and address of person who	mpleted cause of de	ath (Item 23a) (Tyl	Print)	Pla	116	His	hory	Ann	APILLS 1	MD 24401
To the second	Sta Registi		31. Date filed (Month, Day, Year)	32. Registra	's Signature	Louis	م						
DH	MH 17 Rev 1/2		APR 0 3	200 6	196 S.	1							

Robert Cherry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6-2150Unpend item#23a,27,28a-f, per NE 0854, 4/13/06 TT State of Maryland Department of Health and Mental Hygiene KG Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** March 28, 2006 9:39 A Robert Joseph Cherry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner n/a Baltimore St. Agnes Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09/03/1985 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1**X** M 2□ F MD 20 220-08-4662 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County tina State Hygiene. other then "naturel", or items 23a or 28e-f show ent, the Macinal Examinar must be notified at 1 Yes 2 No Director Glen Burnie Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21060 914 Pine Road withIn 72 hours after death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 M Never Married 2 ☐ Marned Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ۾ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Door Mechanic Construction 12 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked eny injury or other traumatic evone. and Mental is marked Barbara Lou Jackson Joseph Robert Cherry, Jr. 2 19a. Informant's Name/Relationship (Type, Print) Father 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 914 Pine Road, Glen Burnie, MD 21060 Joseph R. Cherry, Jr./ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Glen Haven Mem Pk 04/03/06 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Euneral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final disease or condition resulting in death) Fentanyl and diazepam intoxication Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Own to for as a consciousness off: attending physician and for use as the burial-transit the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): .O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown signed by d be detact ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 Yes 2 No 3 Probably 4 Munknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ Yes 2 □ No 24a. Was an autopsy performed? 12 Yes 2 □ No Division of Vital Attending Physicien: 26. Place of Death Check only one director, 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 XYes 2 ☐ No Medical Certification: To this After thi funeral 28a. Date of Injury (Month, Day Ye 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Fnd 3/28/2006 Fnd 9:00A M 1 Natural 5 Pending 1 ☐ Yes XX No death. unk investigation spital or Attendi lours after death. neral Director: A filled in by the fu 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
in vehicle 3 Suicide 28f Location (Street and Number or Rural Route Number, City or Town, StateRear of 1530 Canton Ctr. 4 Homicide Halethrope, MD To the Hospital
within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 29, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21201 MA RUB10 MD 111 Penn Street, Baltimore, Maryland

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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32. augistrar's Signature

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	/Medic Examir		4a. Facility Name (If not institution, give		iber)	Coll		Town, or	Location o	f Death	MARCH	25 4c.	. County of De	ath	10 P
			1906 Holborn Roa  5. Social Security Number 6. Se		7. Age (In yrs.	last hirthday)	If Under	1 Year	ndalk If Under 2		8. Date of Bir	th	Baltin		or Foreign
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	th the N or 28a-1 e notifi	Director	10e. Street and Number				10f. Zip					10g. Cit	izen of What (		
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36	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or items 23e or 28a-f show event, if a Madical Exerting transle notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Deced Armed For 1 Tes If Yes, Give Year or Da	ces? 2▼]No		Was Oeceo f Yes, spec 1 ☐ Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	)-	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White	
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ıland	2 should be filed and Mental Hygi is marked other eumetic event,	To Be	17. Father's Name (First, Middle, Last) Samuel Duckworth						18. Mother	r's Name	(First, Middle, Eliza		<i>Sumame)</i> h Mille	er	
Mary	d 2 sho th and h treume		19a. Informant's Name/Relationship (7) Mr. James Applek			1					Route Number			. Zip Code) Maryland	3 2110
	ges 1 and 2 should it of Health and Men If Item 27 is marke or other treumetic		20a. Method of Disposition 1 Burial 2 Cremation 3			Place of Disponentery, cren	sition (Nan	ne of	1		ate		ocation - City o		
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	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):								2.00	•
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Divis	after Digital	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At hog, etc. (Specify	ome, farm, stre	et, factory	office		2	8f. Location (5 City or Tox			Rural Route Num	ıber,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the b ner: On the bas and manne	is of examinat	wledge, death tion and/or inv	occurred a estigation,	it the time	e, date and inion, death	place, ar	nd due to the o	cause(s) date and	and manner a place, and du	as stated. se to the cause(s	;)
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ŋ	a		30. Name and address of person who co				Print)	24				100	reh 2	1) 4	00
	) Sta	20	THOMAS FINUCANE, 31. Date filed (Month, Day, Year)		05 Hopi gistrar's Signal	KINS BAY	MIEM	CIRCL	EBA	LTIMO	RE, ME	>212	224		
	Registr		APR 0 3 20	3/		s for	whi								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Lucille Carder Davis 5:45 P M March 29, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Manor Care Rossville Rossville Baltimore Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 13 F Yrs. 82 March 3,1924 Director 225-22-2108 Virginia Usual Residence of Decedent 10b Counts 10c. City. Town or Location 10a State 10d. Inside City Limits 28e-f show the Medical Exactine must be notified at Dundalk 1 Yes 2 No Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 21222 2700 Gray Manor Court United States iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ᢓ⊋No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married ö 1 ☐ Yes 2 ☑ No Specify: Specify δ 3 ₩ Widowed 4 Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Assembly Line Worker Manufacturing 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H is marked of . Pages 1 and 2 should be treent of Health and Menta Charles A. Davis May C. Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 2713 Gray Manor Ct. Mr. Steven A. Carder (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Molly Hill Mem. Gdns. 4/3/2006 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign were of Funeral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Conorman Mercy Diseau **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated enterlying Cause (Disease or injury) Examiner attending physicien and for use as the burial-transit certificate be executed Status Port that initiated events resulting in death) Last Oue to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Nevh aema 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Tyes Physicien: director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No င္ this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Division usi or Ah.

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vi Director: An.
in by the fire 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide within 24 hours e To the Funeral ( the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31106 D 31464 MD 30. Name and addre, s of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST Sinte 308, BALTMORE MD 2/20 5 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 3 2006 Registra

Baltimore, Maryland 21215-0036

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First\_Middle, Last) Year **Physician** OsePh Chestnu 1626 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mospital Baltmore Baltmore 9. Birthplace (State or Foreign
County) Cambra If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day 7. Age (In yrs, last birthday)
Yrs. Social Security Number 6. Sex **Funeral** -30 16 M 2 F Director Usual Residence of Decedent 10h County 10a. State 10c. City, Town or Localic 10d. Inside City Limits or 28a-f show is marked other than "natural", or Itame 23a or 28a-f ebov raumatic event, the Medical Examinar most be notified at 1 Ves 2 □ No Marylan Funeral Directo 3307 W 10f. Zip Code 10g. Citizen of Whal Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 D res 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedenl's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame, Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau Baltimore Man ristine 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funds of Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Canco /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4- Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has the 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi funeral of 28a. Dale of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier BS9316527

Registrar

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSP:

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 25. 2006 Year **Physician** Dewey Craig, Sr. 16:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3502 Delancey Street Prince George's Clinton 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Month, Day, Year) Aug. 8, 1932 9. Birthplace (State or Foreign **Funeral** 1∭M 2□F Director 577-44-1883 Washington DC Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or itema 23a or 28a-f ehow the Medical Exampler results be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3502 Delancey Street 20735 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours atter death 1 Department of Heelth and Mental Hygiene. Important: If Itam 27 is marked other than "nature!; or itema 23e eny injury or other traumatic event, the Medical Exantines transit once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No 1950 − If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Washington Metro Elementary/Secondary (0-12) 8th College (1-4or 5+) Bus Mechanic Transit Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stephen Mayo Minnie Lindsay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Craig (wife) 3502 Delancey Street Clinton, Maryland 20735 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 31. 1 Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old ALexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Contact Gunshot Wound to Head /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Examine physiclen and s the burial-transit Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) this certificate has been signed by the and director, page 2 should be detached Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☒ Yes 2 ☐ No 24a. Was an autopsy performed? 1∑ Yes 2□No oapital or Attending Physicien: 'hours atter death.' unerat Diractor: Atter this certifica ly filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 AOther (Specify) 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA SCENE 28a. Date of Injury 28b. Time of (Month, Day Year) 28b. Time of (Work?) 28c. Injury at Work? 27. Manner of Death Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 4:27 SUBJECT SIXT Self 25 46 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 35LL DELMG9 St., To the Hospital o within 24 hours at To the Funeral Di Clintery Home mD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MiD. 6/20,50 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. A su strar's Signature State

DHMH 17 Rev 1/2001

Registrar

2006

			For State	State of Ma	iryland.	-	artment of F tificate of		•	0007	10100	
			Registrar  1. Decedent's Name (First, Middle, L	.ast)		- 007	tineate or	Death	2. Date of De	Reg. No.	3. Time of Death	
ı	Physici /Medic		James Walton	Coley					March	29°, 2006	7:45 AM	
	Examin		4a. Fecility Name (If not institution, g		"		_ ′′	r Location of Death		4c. County of I		
			18809 Sparkling				Germant		The		omery	
	Funeral Director	ľ	240-34-5412	Sex 7. Age	79	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 2	9, 1926 No	Birthplace (State or Foreign Country) rth Carolina	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limits	
	Maryl f sho	Ď	Maryland Montgom	erv	Germ	antow	m				1 ☐ Yes 2X No	
	r 28a	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	t Country?	
	th wit	aiD	18809 Sparkling	Water Drive	#203		20874			United S	States	
36	o 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show scioul Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∭Yes 2 ☐ N If Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cuba I ☐ Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
ž	2 hou	ted	15. Decedent's I	Education	1	6a. Deced	lent's Usual Occup	ation		16b. Kind of Busin	ess/Industry	
215-0036	thin 7	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5-	+)	(Give . life. [	kind of work done 30 NOT use retired	during most of work d)	ing		County Board	
	filed within Hygiene. other than "	Con		5+			Editor			of Educ	ation	
Maryland 2	0 = 0 5	Be	17. Father's Name (First, Middle, Las James Tilden		e (First, Middle, rown	, Maiden Sumame)						
<u></u>	shoul nd Me mark	բ	19a. Informant's Name/Relationship	er, City or Town, Sta	te, Zip Code)							
	aith a		Mary J. Cellucci	A 30319	115							
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones.		20a. Method of Disposition  1   ☐ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		Pate3,	y or Town, State  Maryland						
Balt	permit. Departn Imports any inju		21. Signature of Funeral Service Lice	al Home.	Rockville,	Inc.						
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death. [	Do not ente	er the mode of dyin	g, such as cardiac o	or respiratory a	rrest,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Pneumo							Onset and Death Two Days	
	/Medical Examiner		resulting in death)	Due to (or as a	consequen	ce of):		<u> </u>				
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28/60	ificate be of physicial as the buri	edical		<b>d</b> .			_					
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, Č	requires that the neen signed by th hould be detache		Part II. Other significant conditions	contributing to death bu	t not resultin	g in the un	iderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	te to the cause of death?	
ä	equire en sig ould b	ted t	Hypertension						101	Yes 2□No 3□	Probably 4 🛣 Unknown	
ပ္က	4 20	Completed by	Hyperlipidemia				<u> </u>		24a. Was autop perfo 1 Yes	an 24b. Were prior med? deat	e autopsy findings available to completion of cause of h?  Yes 2 No	
<u> </u>	ctor.	Bec	25. Was case referred to medical examiner?					26. Place of Death				
5	hysic this o	၉	1 ☐ Yes 2 🖔 No	Hospital: 1 Inpatien		_		4 LI Nursing Hor		dence 6 Other (	Specify)	
	ding F th. After funera	Certification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Injury (Month, Day	Year) 281	b. Time of Injury	28c. Injun Worl	/at k? Yes 2 □No	28d. Describe h	now injury occurred		
UNISION	Atten	ifica	3 Suicide 6 Could not determined	be 28e. Place of Injur	ry - At home	, farm, stre			28f. Location (S	Street and Number o	r Rural Route Number,	
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	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai (	29a. Certifier 1  Certifying P (Check only one) 1  Medical Exa	Physician: To the best of aminer: On the basis of and manner stat	examination	dge, death and/or inv	occurred at the tin estigation, in my o	ne, date and place, a pinion, death occurr	and due to the ed at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier				29c. License	e number		29d. Date signed (M	lonth, Day, Year)	
			Musty 4	MID			D3183	19		March 3	31, 2006	
. 0	Lorl		30. Name and address of person Christopher L. 1	Ounford, M.I	61	5 W.	Montgome	ery Avenue	e, Rocky	ville, MD	20850	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 3	32 Aegistra	r's Signature	A	who					

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ı	Physici	an	1. Decedent's Name (First, Middle, Las	-							2. Date of Dear Month	Day Y	ear	3. Time of Dea 5: 46am	ith M
	/Media	cal	Ruth S. Davis  4a. Facility Name (If not institution, give				4h Cihr I	Four or	Location o	f Dooth	March 9,	2006 4c. County of	Doath	J. 40att	
1	Examir	ier	Fort Washington						hingt						
	Funeral		5. Social Security Number 6. S	7. Age	(In yrs. last birth	day)	If Under	1 Year	If Under		8. Date of Birth (Month, Day,	Prin	. Birthp	Georges lace (State or Foi try)	reign
	Director		420-32-3262	□M 2/25 F	87 Yr	s.	Months	Days	Hours	Min.		1/1918	Coun	try) AL	
	p .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town									0d. Inside City Li	-/
	e Maryla Sa-f shor	Director	MD Prince				Fort	Wash	ingto	on				17€1¥es 2 □	
	th with th	al Dire	10e. Street and Number 703 Overview Co	urt			10f. Zip (	Code	20	744	1	0g. Citizen of Wha	at Coun	try?	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other traumatic event. Ite Modical Exam are rinted by routiled at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ĀNo If Yes, Give Year or Dates:	er in U.S.		Vas Decede Yes, speci		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. Race - Black, Specify:	White,	∍tc.	
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Maryland	uld be file Aental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, Last) Willie J. Seaw	right							(First, Middle, M Le Lee J	Maiden Sumame) Iones			
	nd 2 sho alth and h 27 is ma		19a. Informant's Name/Relationship (T Annette Boxley D	• • • •								, City or Town, Sta shington		<sup>Code)</sup> 20744	
Baltimore,	Pages 1 annent of Heamant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		20b. Place of D cemetery, GreenWC	crem	atory or off	her olace	) Ma			20c. Location - Cit Montgom	•		
Balt	permit. Departr Imports eny inju		21. Signature of Funeral Service Licen	See		22.	Charl 1501	les L	. Stev	ens Fl	neral Ho Baltimore	me Inc. MD 21230			
8760,	death certificate be executed xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx	edical Examiner	23a. Part1. Enter the disease, or configurations shock, or heart failure. List only a limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to (or as a of Due to (or a) Due	consequence of)	; ,~.o	ARA		, such as c	cardiac of	respiratory arre	est,		Approximate Interval Batween Onset and Death	
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Δ.	·= 0 0	by	Part II. Other significant conditions co	entributing to death but	not resulting in th	ne und	derlying ca	use give	n in Part I.		23e. Did tob	pacco use contribu		e cause of death	
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Divisi	i or Attending Physicien: after death. Director: After this certific i in by the funeral director.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.		, stre	et, factory,	_			8f. Location (Str City or Town	reet and Number o	or Rural	Route Number,	
-	Hospite 24 hours Funerel stely filled	edicai C	29a. Certifier (Check only one) 1 Certifying Physical Example 10 Medical Example 10 Medic	rsician: To the best of a iner: On the basis of ear and manner state	camination and/c	leath or inve	occurred a estigation, i	t the time	e, date and nion, death	place, ar	nd due to the ca d at the time, da	use(s) and manne ate and place, and	r as sta due to	ited. the cause(s)	
	To the within 2. To the complet	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date signed (N	fonth, E	Pay, Year)	
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1	21		30. Name and address of person who d	ompleted cause of dea	th (Item 23a) (Ty	pe, P			17.3	5	0	7/1/2006			
	U		31. Date filed (Month, Day, Year)	(Lens) D C	Signatura	1	DINY	w		722	10001	1 tog	) ;		
	Sta Registr			32. Agistrar's	Signature	1	well.	V							

			1 - For State Registrar	State of Maryla		artment o			Re	g. No. 0	6	10132
	Physici /Medic		1. Decedent's Name (First, Middle, Last ALFRED, T, FINI						2. Date of Death Month March	Day	Year 2006	3. Time of Death 20 120 PM
	Examir		4a. Facility Name (If not institution, give UNION HOSPITA			EIL	cton			4c. County	IL	
	Funeral Director		5. Social Security Number 6. Se 166 2 0527 15		rs. last birthday)	If Under 1 \ Months D	Year Days	Hours Min.	8. Date of Birth (Month, Day, June 1,1	Year) 923	9. Birthpl Coun Elkt	ace (State or Foreign try) On, MD
	Maryland f show	jo.	10a. State 10b. County MD	10c.	City, Town or Lo Risir	cation ng Sun					10	0d. Inside City Limits
	with the Page or 28a-	i Direct	10e. Street and Number			101. Zip Co			10	g. Citizen of \	What Coun	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates:			t of His Cuban	spanic Origin? (Spe , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	e - America k, White, e Whit	etc.	
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Maryland	ould be file Mental Hy arked oth atic evant	To Be	17. Father's Name (First, Middle, Last)  ROCCO Finizi						e Rutigl			
, Mar	and 2 sh eaith and m 27 is m	9	19a. Informant's Name/Relationship (T) Tom Finizio / Sor	1	6848	Rever	e S	od Number or Rura Street Ph	iladelph	nia,PA	19149	
Baltimore,	Pages nent of ant: If it		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Place of Dispo cemetery, cren Esurrecti	on Cemel	r place ery	March 2006	ı 13,	Densa	lem, PA	
Bal	permit. Departnimports any inju	į į,	21. Signature of Fulleral Service Licens	>>		1501 E	s L. est ]	Stevens Fu Fort Ave B	<u>altimore M</u>	D 21230		
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	congestion caused line.  CONGESTI  Due to (or as a cons	VE HE		AIL	URE	r respiratory arre	st,		Approximate Interval Between Onset and Death
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P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physicien end 2 should be detached for use as the burial-transit	nysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregr Other (specif				23d. Dat	e of deliver	ry Day Year
	w requires that been signed b should be deta	۵	Part II. Other significant conditions con	ntributing to death but not r	esulting in the ur	nderlying caus	e giver	n in Part I.		acco use contr s 2 □ No	nbute to the	e cause of death?
Records,	The law req ate has beer page 2 shou	Completed							24a. Was an autopsy perform	ed?	rior to corr leath?	sy findings available apletion of cause of
of Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	lospital:			Other	26. Place of Death				
	ding Phys  After this funeral di	tlon; To	1 Yes 2 No Cannon Yes 2 No Cannon of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	4   Nursing no	me 5 🗌 Resider 28d. Describe hov			)			
Division	al or Attanding s efter death. ii Diractor: After id in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	micide determined 286. Place of Injury - At nome, farm, street, factory, office building, etc. (Specify)								Route Number,
	To the Hospital or Att within 24 hours efter d To the Funaral Diract completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death	occurred at the restigation, in	he time my opi	, date and place, a nion, death occurre	and due to the car ed at the time, da	use(s) and ma te and place, a	nner as sta and due to	ited. the cause(s)
	Totl withi Totl	Ň	29b. Signature and title of certifier	MP				63486		d. Date signed		,
6	, 8		30. Name and address of person who co	ompleted cause of death (It	y are.	B) Ks	ا ا ده	ND ZIG		C	· · · · · · · · · · · · · · · · · · ·	
₹	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature	hadi)						

			1 - Stata Ragistrar Amend Item	State of Maryla					giene 006	10133			
H	Physici		Decedent's Name (First, Middle, Last)     MORRIS			FRID		2. Date of Dea MARCH	28, 2006 ear	3. Time of Death 5:26 P M			
	/Medio Examir		4a. Facility Name (If not institution, give s 3204 OLD POST DR			4b. City, Tow		TIMORE	4c. County of Dea	.TIMORE			
	Funeral Director		5. Social Security Number 6. Sex 108-09-5002	7. Age (In y	rs. last birthday) 7 Yrs.	If Under 1 Your Months Da	ear If Under 24 ays Hours N	Hrs. 8. Date of Bird Min. AUG. 15	9. Bir	thplace (State or Foreign RUSSIA			
	Maryland a-f ehow	ctor	10a. State 10b. County  MD BALTIM		City, Town or Lo	TIMORE				10d. Inside City Limits			
	n with the	Funeral Director	10e. Street and Number 3204 OLD POST DR	IVE #7		10f. Zip Coo	212		10g. Citizen of What Co	ountry? USA			
036	within 72 hours atter death with the Maryland ene. Then "natural", or items 23e or 28e-f ehow the Madical Examination multiple at	þ	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced		ARMY	Was Decedent If Yes, specify ( 1 ☐ Yes 2 💢		? (Specify Yes or No uerto Rican, etc.)	- 14. Race - Ame Black, Whi Specify:				
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By Injury or other traumatic event, the Madical Examinar must be multipled at angle.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Oo kind of work do DO NOT use re PRIETOF	one during most of etired)	working	16b. Kind of Business MURRAY DIS	f Business/Industry Y DISTRIB. CO.			
Maryland	uld be file Mental Hyg irked othe itic event,	To Be C	17. Father's Name (First, Middle, Last) DAVID	JOSHUA	FR	ID	18. Mother's	Name (First, Middle, A	Maiden Sumame)	TZIPRIS			
, Mar	and 2 sho salth and I n 27 le mu er traums		19a Informant's Name/Relationship (Ty)	IFE	3204	OLD POS	ST DRIVE		er, City or Town, State, IMORE, MD 2				
Baltimore,	Pages 1: nent of He int: If iten iry or oth		20a. Method of Disposition 1 🛱 Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	o. Place of Dispo cemetery, cred NESSETH	matory or other	place)	/31/2006	20c. Location - City or ANNAPOL IS				
Balt	Departi Departi Imports any Inju		21. Signature of Funeral Service ticense		2:	2. Name and A	ddress of Facility	SOL LEVII	NSON & BROS PIKESVILLE	., INC.			
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al Keco	i: The law re cate has be page 2 sho	Completed								utopsy findings available completion of cause of			
Division of Vital Records,	To the hospital or Atlanding Prysician. The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of eath 1 Natural 5 Pending investigation	ospital: 1  Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c.	0.15		nne)  dence 6 Other (Spe	ocify)			
	tal or Atten	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str ecify)	eet, factory, off	lice	28f. Location (S City or Ton	Street and Number or R vn, State)	ural Route Number,			
:	o the Hospital within 24 hours to the Funeral completely filled	edicai	29a. Certifier (Check only one) Certifying Physical Examination)	sician: To the best of my liter: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at th vestigation, in r	ne time, date and pi my opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)			
)	vithin 2 To the comple	Σ	29b. Signature and title of certifier	un			23074		29d. Date signed (Moni	th, Day, Year)			
	6		30. Name and address of person who co	D/hmm	tem 23a) (Type,	Print) 730	23076 Falls 19	Real .	3)29/4 But M	e 2)211			
	Sta Registr		31. Date filed (Month, Day, Year)	34. Registrar's Sig	nature	de la							

State of Maryland / Department of Health and Mental Hygiene 🕕 🖟 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 28 2006 2006 FOX SONIA 11:55 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 6218 NORVO ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) UKRAINE **Funeral** 1□M 2□F Yrs. Director 213-48-4815 85 Usual Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits other than "natural; or Itams 23a or 28a-f ehow vent, the Medical Examiner must be notified at BALTIMORE BALTIMORE 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6218 NORVO ROAD 21207 USA Funeral Pages 1 and 2 should be filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No þ Specify. 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME ulth and Mental Hygie 27 is marked other r traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WINOKUR RUTH (UNKNOWN) ISAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tam 27 9207 BROKEN TIMBER WAY - COLUMBIA, MD 21045 GAIL FOX / DAUGHTER tam 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of h Important: If its any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CEMETERY 03/31/2006 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signature of Funeral Segrice Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) and Death **Physician** Hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed physicien and the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical anding pt 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant etter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 3 Probably 4 Striknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 1 esidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending ours after death. neral Director: Aft filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 - Homicide Hospital Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51896 Willer ME D dress of person who completed cause of death (Item 23a) (Type, Print) ous Wa

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 0 3 2006

Registrar's Signature

			For State Registrar	State of Maryla	•	artment of rtificate of			giene	10135
	Dhusini		Decedent's Name (First, Middle, Latter)	st)				2. Date of Dea Month	ith Day Year	3. Time of Death
	Physici /Medic	al .	Lucille		GYE			Month	1 2001	
Mer	Examin	er	4a. Facility Name (If not institution, given Bon Secours Ho				, or Location of Dea altimore		4c. County of Dea	th
4	Funeral		Social Security Number     6. S	ex 7. Age (In yr.	s. last birthday,	If Under 1 Yea	ar   If Under 24 Hr			thplace (State or Foreign
	Director		217 30 0013	□M 25xF 67	Yrs.	Months Day	rs Hours Mir	April		N.Carolina
	and		Usual Residence of Decedent  10a. State 10b. County	10c. 0	City, Town or L	ocation				10d. Inside City Limits
	Maryli fint	ţō	MD N/A	<i>Y</i> 1	Baltim	ore				Yes 2 No
	d within 72 hours after death with the Maryland liene r than "natural", or Itema 23a or 28a-f show The Medical Exatricat must be matified a	by Funeral Director	10e. Street and Number 1401 N. Lakewo	ood Ave Apt	t # 20	10f. Zip Code	21213		10g. Citizen of What C	ountry? USA
"	fler death r Itema 2	Funera	11. Marital Status 1 □ Never Married 2 → Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No			of Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Whi	
21215-0036	ours a		3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2□N	lo Specify:		Specify: B	lack
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	be filed tal Hyg d other event,	Be C	17. Father's Name (First, Middle, Last,	**	110	ube WI	18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
ylar	Menta Menta arked	To E	Elzie Jones					ie Morga		
Maryland	nd 2 shu alth and 27 is m r traum		19a. Informant's Name/Relationship (David L. Grego	**	19b. Mail	ng Address (Stre N. La	et and Number or F kewood	Rural Route Numbe Ave Balt	r, City or Town, State, cimore MD	Zip CodApt 201 21213
Baltimore,	Pages 1 an nent of Heal int: if Item 2 iry or other		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State .	comptoni cro	osition (Name of matory or other of ille V	A Cem 4,	Date /7/2006	20c. Location - City of Crownsvi	
Balti	permit. Pa Dapartmen Importent: eny Injury once.		21. Signature of Funeral Service Licenter Willer	see Wils	5	2. Name and Add	dress of Facility Cl	natman-H own Rd H	Harris Fu Baltimore	neral Home MD 21215
760,	Physician /Medical Examiner	Ical Examiner	23a. Part Lenter the disease, or com shook, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions, any laboration immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cons)  Due to for as a cons  Due of or as a cons  Due of or as a cons	quence of):	She	elemon		Sún.	Approximate Interval Between Onset and Death Weok
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ital	ysician: Th is certificete director, pag	BeC	25. Was case referred to edical examiner?	VILLACON	lare	uac a		eath (Check only o		
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ou C	ding Phi th. After thi funeral	lon:	27. Manner of Death  1 Vatural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		njuryat Nork? □Yes 2□No	28d. Describe r	now injury occurred	
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۵	lospital or A hours after uneral Dire								•	
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1	21		30. Name and address of person who							
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	Regist	_	APR 0 3 20	32. Registrar's Sig	or popular	well				

			1 - For State Registrar	State of Marylar				ealth ar Death	nd Me		jiene	006	10136		
	Physici		1. Decedent's Name (First, Middle, Last)	Bernice F	. Giza	nski			2	Date of Dea Month	th Day	2 Ye	3. Time of Death	А	
>	/Medio	er	4a. Facility Name (If not institution, give to the facility Name)  5. Social Security Number   6. Security Number	Hoxarta	last hirthday	X	Town, or	Location of I	e	. Date of Birth	1	County of C	Death  Birthplace (State or Foreig		
	Funeral Director			м 21xf 85	Yrs.	Months			Min.	(Month, Day	, Year) 5,19		ennsylvania		
	Maryland -f e-how	tor	10a. State 10b. County	timore 10c. Ci	ty, Town or Lo	cation		Dui	ndalk	ζ			10d. Inside City Limits 1 ☐ Yes ※※No		
)	with the a or 28a	Director	10e. Street and Number 2439 Fairway			10f. Zi	p Code	212	22	1	-	zen of Wha	states		
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "naturel", or tems 23s or 28s-f ehow other then "naturel", or tems 23s or 28s-f ehow event, the Medical Examiner must be multiled at	by Funerai	11. Marital Status  XX Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Dece f Yes, spe 1 \( \text{Yes}		spanic Origin n, Mexican, f Specify:	n? (Specif Puerto Rid	ly Yes or No- can, etc.)	1	14. Race - American Indian, Black, White, etc.  Specify: White			
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Mary	2 sh and em		19a. Informant's Name/Relationship (Ty Mrs. Constance M.	•	· Y ====					Route Number	60	99 8	5 52	ı	
ore,	Pages 1 and 3 nent of Heelth int: If Item 27 iry or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. I lemoval from State	Place of Dispo	sition (Na natory or	me of other plac		Date		20c. Lo	cation - City	y or Town, State		
Baltimore,	permit. Pages 1 Department of H Important: If ite eny Injury or ot		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens			Name a	nd Addres	s of Facility	ral 1	Home of	f Du	ndalk	e, Maryland  i, Inc. 21222		
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	To th within To th comp	Me	29b. Signature and title of certifier				c. License					-	Month, Day, Year)		
	_	1	30. Name and address of person who co	ompleted cause of death (Ite)	m 23a) (Tvne		<u> </u>	5000			, , , , ,	W 3	1,2006		
	15	1	Dr. Stuart Will	es 9000 F	ankl	un s	Shi	Driv	er	attin	nore	- M	D 21237		
	Sta Regista		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature	and I	V								

			For State Registrar	State of Marylai	•	artment of F rtificate of			iene 2006	10137			
*(*)	Physici		Decedent's Name (First, Middle, Last)	John Balfo	117	Guthrie		2 Date of Dear Month March 3	Day Year	3. Time of Death 9:10 A			
	/Medic Examin		4a. Facility Name (If not institution, give	Daile	ur		or Location of Deat		4c. County of Deat				
		. ## 30	8141 Mid Haven Ro	pad		Dur	ndalk		Baltimore				
×.	Funeral	30.[4]	Social Security Number     6. Sex	9 . 1 ,		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		of Birth th, Day, Year)  9. Birthplace (State Country)				
	Director		214-24-4358	tm 2□F 77	Yrs.			Aug. 4		land			
	and		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits			
	Maryl 1 etho	ō	Maryland Ba	altimore		Dundal	Lk			1 ☐ Yes 2XXVo			
	288-	Director	10e. Street and Number	ar camor c		10f. Zip Code		1	0g. Citizen of What Co	untry?			
	3a or		8141 Mid Haven Roa	ad			21222		United Sta	ates			
	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame	rican Indian,			
ဖွ	or Ite	3	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 XYes 2 No If Yes, Give		1 ☐ Yes ŽXXNo		o rican, etc.)	Black, White	e, etc.			
003	ural',	d by	3 Widowed 4 Divorced	Year or Dates: 1945	-48				Specify:	White			
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f ehow the Medical Exercit or mastice rodified at	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business/	Industry			
2	withir ene. then	ф	Elementary/Secondary (0-12)	College (1-4or 5+)		ruck Dri	•		Trucki	na			
	Hygin Hygin	ပိ	7 Years 17. Father's Name (First, Middle, Last)			LIUCK DII	1	ne (First, Middle, I		9			
<u>a</u>	ld be lental ked o	To Be	Samuel James Gut	hrie			No:	ra Thorly	vell				
Maryland	2 should be to and Mental it is marked of raumatic eve	_	19a. Informant's Name/Relationship (Ty	pe, Print)					, City or Town, State, Z				
	and 2		Mrs. Mary D. Guth	rie (Wife)	8141	L Mid Hav	en Road	Dundalk	, Maryland	21222			
ore	of He of He r oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, crea	sition (Name of matory or other place	ce)	Date	20c. Location - City or	Town, State			
<u>Ĕ</u>	Pag ment ant: I ury o		4 □Donation 5 □Other (Specify)	emovar nom state	oreland	d Mem. Pa	rk Cem.	4/3/2005	Baltimor	e, Maryland			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other then "natural", or Items 23a or 28a-1 ehow emportant: If item 27 is marked other then "natural", or items 23a or 28a-1 ehow emportant in items 1 fair in a linear Legisla of once.		21. Signature of Funeral Service License	Masse		Name and Addre uda-Ruck 222 Wise			Dundalk, In aryland 21	.222			
100			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the dea	th. Do not ent	er the mode of dyir	ng, such as cardiad	or respiratory arre	est,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Chronic o	hedr	where of	Inone	my de	ware	Onset and Death			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	0.1							
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	nuence of)	Fibro	515						
th.	nsit	nin	Cause (Disease or injury	12.00 14	0 10 0 6	1							
Į.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	Due to (orlas a conse	quence of):								
760,	ate be executed hysician and the burial-transit	ical		l									
89	tifical ng phy as th		15.55441.5										
Вох	th cer tendir or use	an/N	230. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy	v		23d. Date of deli	-			
o.	The law requires that the death certificate be execulêd te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5[	Other (specify)			Month	Day Year			
α_	that if ed by detac		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	ndertving cause giv	en in Part I.	23e. Did tot	pacco use contribute to	the cause of death?			
Records,	uires tha signed Id be det	d by			3	, , ,			,	obebly 4 Unknown			
Ö	w requir been si should	Completed						24a. Was a	n 24h Were au	topsy findings available			
Re	he lav e has ige 2	ш			,			autops perforr	y prior to o ned? death?	completion of cause of			
ta		a)	25. Was case referred to medical				26 Place of Des	1 ☐ Yes 2 ath Check only on		2 No			
$\leq$	ysici Is cer direc	To B	examiner? 1 ☐ Yes 2 📉 No	ospital: 1   Inpatient 2	ER/Outpatier	nt 3 DOA Oth	200		ence 6 Other (Spec	city)			
Ö	r Attending Physician: ler death. irector: Atter this certifics h by the funeral director, p		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur			ow injury occurred				
<u>0</u>	endir sath. or: Af he fu	atic	2 Accident investigation		,,		Yes 2 □No						
Division of Vital		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Special	nome, farm, str ify)	eet, factory, office		281. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,			
	Hospital of hours a Funerel C	Ce	00-0-45 1 <b>8</b> 0-45 11-8	To the base of the	- 1-1 - 1 - 1								
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	edicai	29a. Certifier (Check only one)  1. Certifying Phys 2 Medical Examin	sician: To the best of my kn ner: On the basis of examin and manner stated.	ation and/or in	n occurred at the tir vestigation, in my o	me, date and place opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)			
	To the within 2 To the Complet	Me	29b. Signature and little of centifier			29c. Licens	se number	2	9d. Date signed (Month	n, Day, Year)			
)	->F0		Jany Ca	histon 10	m1	000	17170		3/31/06				
,			30. Name and address of person who co	ا المعادات	m 23a) (Type,				3/3/100				
6	+1			in Brenne	Ba	1 timere	MO	212	24.				
	Sta		31. Date filed (Month, Day, Year) APR 0 3 200	32 Registrar's Sign	ature	three							
3	Registr	ar	7111 0 0 200	pulled of	100	-							

NLM 06-02212 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ashley Harris State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Day Month **Physician** ey 31,2006 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore University Maryland Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 M 2 K 9 Months 213-13-6009 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County or 28a-f show in then "natural", or items 23s or 28s-f show the Medical Examinar must be nutified at 1 **2≪**es 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2148 SA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Never Married 2 Married within 72 hours after Blac 1 Yes 2 0 Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life ONOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Setondary (0-12) College (1-4or 5+) (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) To Be and Mental I Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a Informant's Name/Relationship (Type, Print) Health (Itam 27 i Baltimore, Date 20. Location - City or Town, State 20a. Method of Disposition 0 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. 06 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License am Bulto Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final to Clust Gunshot Wound **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence off Examine anding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1. Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 X Yes 2 □ No 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 💢 No been si

Completed by s certificate has b lirector, page 2 s director, Be ٩ this After thi Certification: Director: / To the Hospital or At within 24 hours after of To the Funeral Direct

Day

Year

1:40 A

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 2 No 1 X Yes 26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ▼Yes 2□ No

25. Was case referred to medical 1⊡Yes 2□ No 27. Manner of Death

1 Natural

29a. Certifier

2 Accident

(Check only one)

Hospital: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 5 [] Pending investigation 31/06

28b. Time of Injury LLUKHOWY 28c. Injury at Work? 1 Yes 2 No

Other:

28d. Describe how injury occurred Shot 5 ubject

3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

LYMALL

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1890 North Charles St. Baltime HD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 31, 2006

rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address Southall, MD tamela E.

111 Penn Street Baltimore, Maryland 21201

State Registrar

Medical

31. Date filed (Month, Day, Year) APR 0 3 2006



or Attending Physicien:

			For State Registrar	State of M	aryland / De	partmen e <i>rtificat</i> e			nd Me		giene	106	0 4			
Ye			Decedent's Name (First, Middle,	Last)					2.	Date of Dea	ath Day	Year	3. Time of Death			
	Physici /Medic		Colleen M	c Nally H	eller					03	30					
	Examin		4a. Facility Name (If not institution, University of 1			_	Town, or L		f Death		4c. County of Death					
× A	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birthda			If Under 2	Min. 8.	Date of Birt (Month, Da OV 22	h v. Yearl		place (State or Foreign			
	Director		204-42-3932	1□M 2 <b>X</b> PF 53	} Yrs	IVIOTILIS	Days	110013	N	ov 22	2 <sup>ay</sup> 1 <sup>95</sup> 2 PA Country)					
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location					10d. Inside C					
	Aaryla	ō	Md Carrol	.1	Eldersb	urg							1 ☐ Yes 2 ☐ No			
	the 1	rect	10e, Street and Number			10f. Zip	Code				10g. Citize	n of What Cou	ntry?			
	3a or		1633 Brimfield (	Circle		21	784				USA					
(0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatilt and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show appringuty or other traumatic event, the Medical Exert fair minal to notified at another.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 A Marrie	12. Was Decedent Armed Forces ad 1 \( \text{Yes} \) 2	?		cify Cuban,	, Mexican,	gin? (Specif Puerto Ric	y Yes or No can, etc.)		Race - Ameri Black, White Decify: Whi	etc.			
036	ours a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2L4No	Specify:			S	pecify: WIII	CC			
21215-0036	72 ho	eted	15. Decedent'. (Specify only highest	s Education grade completed)	(G	cedent's Usua ve kind of wo	rk done du	ion iring most	of working		16b. Kind	16b. Kind of Business/Industry				
2	ithin nen	npie	Elementary/Secondary (0-12)	College (1-4or	life	alespe	se retired)				retail sales					
2	led w tygier her ti	S	17. Father's Name (First, Middle, L	act)			-	IR Mothor	r'e Namo (l	First, Middle,	Maiden Si	iden Cumama)				
Maryland	d be findal Hed of	Be	William T. McNa	111y						. Gond		en Sumame)				
Z	thould id Me mark matic	2	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. M	uilina Address	(Street an	nd Numbe	r or Rural F	Route Numbe	er. City or T	own, State, Zi	p Code)			
Ma	ith ar 1th ar 27 Is 1 trau		Richard F. Hell									Md 217				
ō,	Hea Hea Hea Hea Hea Other		compteny crematory or other place)										own, State			
9	Page: ent of nt: If ry or											Sykesville,Md				
Baltimore,	permit. Departm Departm Importa any inju												Chapel			
			23a. Part1. Enter the disease, or o	complications that cause	ed the death. Do not								Approximate Interval Between			
	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition END-STAGE LWER DISEASE (CIrchosis)													
	/Medical		disease or condition resulting in death)		s a consequence of):	F10 E	11 01	3614	JE (1	31111	00.5	,				
	Examiner			Alcoh	sevia											
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	s a consequence of):											
V	xecuted and Il-transi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	с												
90,	be executed iician and burial-transit	Ä	resulting in death) Last	Due to (or a	s a consequence of):											
8760,	ate hys	dicai		d						-						
9	that the death certific ed by the attending p detached for use as		IF FEMALE:	23c. If yes, outcom	e of pregnancy							d Data of data				
Вох	death o	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death	3 □Ectopic pr 5 □ Other (sc					230	<li>d. Date of delive Month</li>	Day Year			
o.	the d	iysic	1 □ Yes 2 No 9 □ Unknown	9□ Unknown	21 11110 01 000111	0 (3p										
۵.,	requires that the een signed by th rould be detache	y P	Part II. Other significant condition	ns contributing to death	but not resulting in th	e underlying o	ause giver	n in Part I.		23e. Did t	obacco use	contribute to	the cause of death?			
rds	iw requires that s been signed t should be deta	q p	Acute renals	failure						10	Yes 2	No 3□Pro	bably 4 🗆 Unknown			
Ö	- 0 to	olete								24a. Was	an :	24b. Were aut	opsy findings available ompletion of cause of			
Re	: The law cate has I	mo								autor perfo	rmed?	death?				
ta	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	of Death (	Check only o						
<b>&gt;</b>	Physician: this certific ral director,	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital: 1 Minpat	ient 2 ER/Outpa	tient 3 DC	Other	. 4 🗆 Nui	rsing Home	5 🗆 Resid	dence 6[	Other (Spec	ify)			
0	ding Phys h. After this funeral did	ü.	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of In (Month, D	ury 28b. Tim	e of 2	28c. Injury a Work?	at	28	d. Describe l	how injury o	occurred				
<u>0</u>	ending sath. or: After he funer	atle	2 Accident investig	ation		М	1 🗆 Y	es 2 🗆 f								
Division of Vital Records,	ter de lirect	ertification;	3 Suicide 6 Could n 4 Homicide determin	ned 289. Place of It	njury - At home, farm, etc. <i>(Specity)</i>	street, factor	y, office		28	f. Location (: City or To		Number or Rui	ral Route Number,			
Ω	urs af	O														
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical		Physician: To the bese Exeminer: On the basis and manner s	of examination and/o											
	ithin o the omple	Me	29b. Signature and time of certifier			290	c. License	number			29d. Date :	signed (Month	. Day, Year)			
	- 3 + ŏ		Nr. M	A w M		T	>198	25			03-	30-0				
	5		30. Name and address of person v	who completed cause of	death (Item 23a) (Tv	on Print\										
			Eric Schwas		29 Sout	n Gree	ne s	treet	- B	altun	ore, M	10 915	101			
10	Sta	ate	31. Date filed (Month, Day, Year)													
	Regist	ar	APR 9 3 20	06 Blees	trar's Signature	de s										

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 12:50 AM **Physician** ne March 2006 a 20 var /Medical 4c. County of Death 4b. City, Town or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 1206 eth rsing enter more a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 10 M 2□ F 037-07-0829 94 Vrs Nov. 10, 1911 Providence, RI Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. Count 10a. State or 28e-f show treumatic syant, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No MD Anne Arundel Severn Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7903 Elberta Drive 21144 USA 238 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. itama s 1 and 2 should be filed within 72 hours after f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Ita 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 White Specify: 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) UNK. NUL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Heanev Mary McDermott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Terry Donovan/Daughter 7903 Elberta Drive Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Department of H
important: if its
any injury or ot March 23. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Aemoval from State Cranston, RI St. Anns Cemetery 2006 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc.
1501 Fast Fort Ave Baltimore MD 21230 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -ears Pnysician oronar disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): signed by the attending physicien a signed by the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown SIGN page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 2 **X** No Hospitel or Attanding Physician: Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) Certification: To 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29b. Signature and title of certifier

State Registrar 23a) (Type, Print)

veni

enson

32. Registrar's Signature

Maryland

. Name and address of person who complete course of death (Item

31. Date filed (Month, Day, Year) APR 0 3 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Day 2006 **Physician** March 26, 7:28 Рм Charles Dickinson Hawley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery 5901 Folkstone Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Oct. 18, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1⊠M 2□F Iowa 511-28-4249 73 Director Usual Residence of Decedent the Manyland 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 X No Rethesda Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 20817 United States 5901 Folkstone Road Iteme 23a Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Iteme 23 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. I X Yes 2 □ No
If Yes, Give
Year or Dates: 1957–1975 1 Never Married 2K Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Callege (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Dickinson Kimball Charles Arthur Hawley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5901 Folkstone Road, Bethesda, Maryland 20817 Teresita V. Hawley/Wife 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Arlington National Cemetery permit. Pages Department of important: If It any injury or o April 13, 1 Burial 2 Cremation 3 Removal from State Arlington, Virginia 4 □ Donation 5 □ Other (Specify) 2006 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Chase. Inc. 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/ Chase, In 17557 Wisconsin Ave., Bethesda, MD 20814-3501 M00198 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multi Infarct Dementia **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Tany leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year ğ Month Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be Toxic Megacolon 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Be Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 ⊠Natural 5 Pending 1 ☐ Yes 2 □ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Control the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated ş 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0026571 March 28, 2006

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

10215 Fernwood Road #401, Bethesda, Maryland 20817

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Irving Mizus, M.D.

31. Date filed (Month, Day, Year)

APR 0 3 2006

		For Stete Registrer	State	of Mary	/land / I		artment of H				giene Rog. No			1011	Beed
		Decedent's Name (First, Middle	e, Last)							2. Date of De	ath	UUC	1	3. Time of Dea	ath
Physicia		Colette Mary	v Howard							Month March	27 Day		ar	8:12P	М
/Medic Examine		4a. Facility Name (If not institution		number)			4b. City, Town, o	r Location	of Death	Har CH		County of D	eath	0.121	
Examilie	ÇΙ	8767 Preston I		,			Chevy	Chace			M	lontgo	meri	7	
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	n yrs. last bi	rthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th	9	Birthpla	ce (State or Fo	reign
Director		220-50-7819	1□M 2 <b>X</b> )F		64	Yrs.	Months Days	Hours	Min.	July 2	$4 \cdot 19$	941 I	Countr rel	V)	
	İ	Usual Residence of Decedent													
ylan how		10a. State 10b. County		10	c. City, Tow	vn or Lo	cation						100	d. Inside City Li	
a-f-	Sto	Maryland Montg	omery	(	Chevy	Cha	se							1 ∑ Yes 2 [	]No
or 28	Director	10e. Street and Number					10f. Zip Code				10g. Citi	zen of What	Countr	y?	
15 wi	a	8767 Preston H	?lace				20815				Irel	and			
r dea	Funeral	11. Marital Status		ecedent Eve Forces?	r in U.S.	13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - A Black, W			
or It	by Fu	1 Never Married 2 Marr	ned 1 ☐ Yes	Sive No		1	l □ Yes 257 No	Specify:		,		Specify:			
ure!		3 X Widowed 4 ☐ Divorced	Year or	Dates:			21.					White			
nat nat	(Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)											nd of Busine	ss/Indu	stry	
then.												14 1	066		
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d of o	Be	a sue con en ancie									maioon	Out/Airie)			
d Me	Frank Howard Mary  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of										or City o	r Toum Stat	o Zio C	'ada)	
d 2 s th an 7 le trau		Deirdre C. Lang		and			Preston				-			20815	
1 an Heal em 2	ŀ	20a. Method of Disposition	31014/111	-	20b. Place o	of Dispo	sition (Name of			ate Circ		cation - City			
ages ont of		1 Burial 2 Cremation		m State	Mont 20	omer	natory or other place		Marc	h 31,					
it. Partment	-	4 □Donation 5 □ Other (S			Crema	tori	um, Inc.		2006		Beth	esda,	Mai	yland	ma/
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dependent of Health and Mental Hygiene. Insportant: if Item 27 is marked other than "naturel", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified at ONEs.		21. Signature da curerar service	S		***	Be	thesda-C	hevv	Chas	e. Inc.	75	57 Wi	scor	sin Av	enue
	-	23a. Part1. Enter the disease, or	complications tha			3 Be	thesda,	Maryl	and	20815-	-3501			Approximate	
		shock, or heart failure. List	only one cause or	each line.	death. Do	not <del>o</del> nt	or the mode or dyn	ig, such as	cardiac	i respiratory a	11051,		1 1	nterval Between	n th
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		ute C			rest						]	mmedia	te
Examiner		,		o (or as a co			D.						١,	77	
	20	Sequentially list conditions,	U	o (or as a co			Diseae						+ 1	Year	
nsit	흩	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	- (0. 20 2 0.		0.7.									
be executed icien and burial-transi	Examiner	that initiated events resulting in death) Last	c	o (or as a co	onsequence	of):							+		
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The law requires that the death certificate ate hes been signed by the attending physinage 2 should be detached for use as the	edical		d												
eath certific attending p	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, c	outcome of p	regnancy						2	23d. Date of	delivery		
atte after	Sar	in the past 12 months?		obirth 2 ☐ gnant at time			Ectopic pregnancy Other (specify)	, 				Month		ay Year	
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e law requires thet the de hes been signed by the i		Part II. Other significant condition	ns contributing to	death but n	ot resulting i	in the ur	nderlying cause giv	en in Part I	l.	23e. Did t	obacco u	se contribut	e to the	cause of death	า?
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sicie s cert lirect	O B	examiner? 1 X Yes 2 No	Hospital:	Inpatient	2   SB/O	utnation	t 3 DOA Oth	22		ne 5⊠ Resi		C Cothan (C	2		
Phy ar this aral c	<b>⊢</b> ⊦	27. Manner of Death	28a. Dat	e of Injury	28b.	Time of				28d. Describe			респу	***************************************	
th.	흥	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	onth, Day Ye	ear)	Injury		k? Yes 2 🔲	No						
Atter r dea octor by the	fice	3 ☐ Suicide 6 ☐ Could i	ined 289. Pla	ce of Injury	At home, fa	arm, stre	et, factory, office		- 1	28f. Location (			Rural	Route Number,	
afte Dire	Certification:	4 Homicide	bui	Iding, etc. (S	opecity)					City or To	wn, State,	,			
psplt hours inere y fille		29a. Certifier 1X Cartifyin	g Physician: To t	he best of m	y knowledg	e, death	occurred at the tin	ne, date ar	nd place, a	and due to the	cause(s)	and manner	r as stat	ed.	
To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	(Check only 2 Medical one)	Examinar: On the and ma	basis of exa anner stated	amination ar	nd/orinv	estigation, in my o	pinion, dea	ath occurre	ed at the time,	date and	place, and	due to ti	ne cause(s)	
To the To the Complex	2	29b. Signature and Little of certifier	2	1		7	29c. Licens	e number			29d. Dat	e signed (M	onth, Da	ay, Year)	
		1 Run	6-10	Lace	eld		D01	948			Marc	h 28,	200	)6	
3	f	30. Name and address of person	who completed ca	use of death	(Item 23a)	(Туре,	Print)								
2		J./Blaine Fitz	gerald,	M.D	8218	Wis	consin A	venue	, #40	08, Bet	hesd	a, Man	ry1a	nd 208	814
Stat		31. Date filed (Month, Day, Year)	32.	Registrar's	Signature										
Registra	ar	APR 0 3	2006	48 A	13	100									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item #14 Per FH G854 4965 ificate of Death Reg. No. 2. Date of Death

Physician /Medical Examiner

**Funeral** Director

death with the Maryland 28e-f show item 27 is marked other than "natural", or iteme 23s or 28s-1 show other treumstic event. The Nedical Exam not must be notified at Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Health and Mental Hygiene. Importent: If from 27 is marked other than "natural; or iten any injury or other treumatic event, the Medical Exptr. 124.008.

Physician /Medical Examiner

attending physiclen and for use as the burial-transit certificate be executed ed by the a

Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica 24 hours a o the F 2

Division of Vital Records, P.O. Box 68760

1 - State Registrar Amend 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 1+1 HOSPITO HIMORE HOOKIN 8. Date of Birth (Month, Pay, Year) OCT 12, 1940 Birthplace (State or Foreign Country) M.D. If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Social Security Number 6 Sax Months Days Hours 1 ☑ M 2 ☐ F 65 MD 213-38-7171 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State N/ABaltimore MD Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21218 609 Wyanoke Ave Apt # 309 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2√☐No Yes. Give 1 Never Married 2 Married **Black** 1 ☐ Yes 2 ☐ No Specify: Specify: Blaa If Yes, Give Year or Dates: þ 3 Widowed 4x Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BGE Street Light Mechanic 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Florence Jenkins Unknown ဂ္ 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Florence R. Jenkins 3510 Northway Drive Baltimore MD 21234 Florence R. Jenkins Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Pleasant Rest Cem. 1 □ Burial 2 □ Cremation 3 □ Removal from State 4/3/06 Towson MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 23a. Papal. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. 5240 Reisterstown Rd Baltimore MD 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 goy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Nnpatient 2 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide

State Registrar

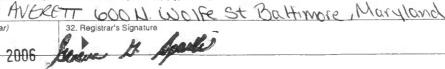
DHMH 17 Rev 1/2001

29a, Certifier

Medical

Lauren NARIE

31. Date filed (Month, Day, Year)



and manner stated.

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

18

29c. License number

			_ For	State of Maryla	nd / Departme	nt of Health and I	Mental Hygien	e	
			1 - State Registrar		Certifica	te of Death	Reg. No	<u>JUU6</u>	0146
7	Physici		1. Decedent's Name (First, Middle, L	ast)	Taylor		2. Date of Death	2006	3. Time of Death
	/Medic Examir		4a. Facility Name (If bot institution, g	ve street and number)	JOYNAY 4b. Cit	y, Town, or Location of Deatl	40	. County of Death	
				ey Ave	13	altimore		NA	
*	Funeral Director		098-20-0382	Sex/ 7. Age (In yrs	. last birthday) If Und Month	er 1 Year If Under 24 Hrs. Days Hours Min.	(Month, Day, Year	23 North	lace (State or Foreign
	/land		Usuel Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Location		)	1	0d. Inside City Limits
	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hyglene. It and Mental Hyglene. If Ie marked other then "naturel", or Iteme 23e or 28e-f ehow traumatic event, the Medical Examana must be modified at	ctor	new York	ne	w York				1 Speres 2 □ No
	with th	Director	10e. Street and Number	1 (6 (6)	10f. 2	ip Code	10g. C	itizen of What Coun	itry?
	me 23	Funeral	11. Marital Status	12. Was Decedent Ever in t	J.S. 13. Was Dec	/8 0 2 9 edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ	
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		ecify Cuban, Mexican, Puert 2 <b>™</b> No <i>Specify:</i>	o Rican, etc.)	Black, White, of Specify: 12 1	etc.
5-0036	hours ture!',	ed by	3 ∰ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a. Decedent's Us		105	Kind of Business/Inc	ch
215	within 72 ene. then na	plete	(Specify only highest g		(Give kind of v	var Occupation rork done during most of wor use retired)	king		,
2	filed with Hygiene. Ither ther	Completed	6		House			ainteno	ince
and	Mental H mrked ott atic even	Be	17. Father's Name (First, Middle, Las			1	ne (First, Middle, Maide		
Mary	2 should and Mer 1e marks aumatic	은	19a. Informant's Name/Relationship		19b. Mailing Addre	ss (Street and Number or Ru		or Town, State, Zip	Code)
× X	C - C -		Clifford Jay	ner sun	4003 C	hasley Ara	. Bulto.	ud. 212	206
lore	S to L		20a. Method of Disposition / 1 ∯Burial 2 ☐ Cremation 3	Removal from State	Place of Disposition (N cemetery, crematory of	ame of other place)	Date 20c. L	ocation - City or To	own, State
altimor	permit. Pag Department Important: I eny Injury o		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic		Kew Cen	and Address of Family	- 2006 Ah	oskie n.	(arolina
Ba	permit. Departr Importa eny Inju		Careta C	Doulan	(ar)	Me Cullah	t. Ball		217
	6		23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications that caused the dea y one cause on each line.	th. Do not enter the m	ode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Pryn	nalgea	Rhemati	Ce,		Onset and Death
	/Medical Examiner		1	Due to (or as a conse	quence of).()	10- Du	200-0		
<i>\$</i>		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse	quence of):	socy so	- Covil		
	be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conse	zertene	lm			
760,	s be ex	calE		PS/Ch	hood (	Jasmlan	dise	ens	
687	Physician: The law requires that the death certificate be executed this certificate has been signed by the ettending physician and rail director, page 2 should be detached for use as the burial-transit			d.	14700		720		
Вох	eath certific ettending p	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 Live birth 2 Fet	al death 3 □Ectopic			23d. Date of delive Month	ny Day Year
P.O. I	at the de by the e tached f	Physician/Med	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4□Pregnant at time of 9□ Unknown	death 5 Cother (	specify)			
ο,	res that igned b be deta	by Pt	Part II. Other significant conditions	contributing to death but not re		•	23e. Did tobacco	use contribute to th	ne cause of death?
ord	w require been sig should b	ted	Degenson	re John	DIFEA	re	1 ☐ Yes 2	No 3 Prob	ably 4 Honknown
Records,	The law a cate has b page 2 sh	Completed					24a. Was an autopsy performed?	24b. Were autoprior to condeath?	psy findings available apletion of cause of
Vital	ician: Th certificate ector, pag	e Co	25. Was case referred to medical			26 Place of Dec	1 ☐ Yes 2 ☐ No		2□ No
f Vi	ysician: nis certific director,	To B	examiner? 1 🗆 Yes 2 🕒 No	Hospital: 1   Inpatient 2	☐ER/Outpatient 3☐ [			6 Other (Specify	Son's Residence
	ding Ph h. After th funeral		27. Manner of Death 1 ⑤ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how inju	iry occurred	
Division	Attending or death. ector: Afte by the fune	ficat	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Injury - At I	nome, farm, street, factor	1 Yes 2 No	28f. Location (Street a	nd Number or Rura	I Route Number.
Ö	s after s after of Dire	Certification:	4 Homicide	building, etc. (Spec	ify)	.,,	City or Town, Stat	e)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	hysician: To the best of my kn miner: On the basis of examin and manner stated.	owledge, death occurre ation and/or investigation	d at the time, date and place on, in my opinion, death occu	, and due to the cause(s rred at the time, date an	i) and manner as st id place, and due to	ated. the cause(s)
	within To the compl	Me	29b. Signature and title of certifier	0		9c. License number	29d. Da	ate signed (Month, i	Day, Year)
)	501			Man	MD	D 31464	4	13/06	
0	L'		30. Name and address of person wh	completed cause of death (Ite	m 23a) (Type, Print)	ITAW ST &	not 308	BALTI	MOREMPHIO
2 S	Sta	te	31. Date filed (Month, Day, Year)	32. Redistrar's Sign		CITIVO 2) 0	NIN SOO	, - , 1	
1.4	Registr		APR 0 3	2008 1000 18 1	J. Assert				

			1 - For State Registrar	State of Ma	aryland		artmen <i>tificat</i>			nd Me		giene Reg. No.	2006	1011.7
	Physici	an	1. Decedent's Name (First, Middle, Last)	1	······································						2. Date of Dea Month		Year	3. Time of Death
· Note	/Media	al	Vera Jacobs  4a. Facility Name (If not institution, give	etreat and number)			4h City	Town or	Location of		March	31	2006 County of Deat	
Ĕ,	Examir	er	University A Maylan		Cont	w	40. City,	Bult	MOVE	2		40. (	NA	••
<i>\$</i>	Funeral Director		5. Social Security Num <b>∮</b> er 76. Sec 240–44–7881		9 (In yrs. la 74	est birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birtl (Month, Day 2-22-	7, Year) -32	9. Birt Co	hplace (State or Foreign untry) N.C.
	ow .		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
	e Man	ctor	Md. NA			Bal	timor	ce						Yes 2□No
	with the	i Director	10e. Street and Number 1400 E. Madison S	Street A	Apt.	1116	10f. Zip	Code 21205				10g. Citiz USA	en of What Co	untry?
36	d within 72 hours after death with the Maryland jiene. r than "naturel", or Itame 23a or 28e-f ehow the Medical Exaction front be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates:	Ever in U.S	1	Was Deced f Yes, spec	ofy Cubar	spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	cify Yes or No- lican, etc.)		4. Race - Ame Black, White Specify: B	
Maryland 21215-0036	nin 72 hour in "nature! Medice! Ex	Completed b	15. Decedent's Edu (Specify only highest grade	cation		16a. Deced (Give life. L	lent's Usua kind of wo DO NOT us	al Occupa rk done di se retired)	tion uring most	of workin	g	16b. Kin	d of Business/	
212	filed within Hygiene. other than "	Com	8th grade	Oollege (1-401-0		Nurs	ing						Varies	
yland	be de la	To Be	17. Father's Name (First, Middle, Last) Jesse			Carter	•			s Name	(First, Middle,	Maiden S		Autry
Man	12 sheh and hand 7 is m		19a. Informant's Name/Relationship (Ty Catherine Jacobs		ator						Route Numbe .more, I		Town, State, 2 21213	(ip Code)
	1 an Heal em 2 ther		20a. Method of Disposition	Daugh	20b. Pl	ace of Dispo	sition (Nan	ne of			ate		ation - City or	Town, State
E O			1 🌠 Burial 2 🗀 Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	lemoval from State		NG MEM	•			1 <b>-</b> 5-0	6	Rar	ndallst	own, Md.
Baltimore,	permit. Page Department Important: if eny injury o		21. Signature of Funeral Service Licens	He		22			s of Facility H. Ea		1101	Balt: E. N	imore, North A	Md. 21202 ve.
8760, 4	Physician and physician and physician and physician and the burlat-transil	ilcal Examiner	23a. Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or a) Du	Cough a consequ a consequ	ence of):		2			rupt			Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic pr Other (sp					2	3d. Date of del Month	ivery Day Year
rds, P	w requires that been signed b should be delt	þ	Part II. Other significant conditions con	ntributing to death bi	ut not resu	lting in the ur	nderlying c	ause give	n in Part I.		23e. Did to	\	e contribute lo	the cause of death?
of Vital Records,		Completed									24a. Was a autop perfor 1 Yes	sv	24b. Were au prior to death?	topsy findings available completion of cause of
Vita	Physician: 'this certifica'ral director, p	Be	25. Was case referred to medical examiner?	lospital: V		DI		Othe	r.		Check only or			
on of	ing After une	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 A Inpatie 28a. Date of Inju (Month, Day		ER/Outpatien 28b. Time of Injury		28c. Injury Work	4 🔲 1401	2	ne 5 ☐ Resid 8d. Describe h		Other (Spec	cify)
Division	ai or Attandi s after death. ii Director: A id in by the fu	Sertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulg	ury - At ho	me, farm, str	eet, factory	y, office		2	8f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Directompletely filled in by	edicai C	29a. Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	examinati									
	To the within 2. To the complete	Me	29b. Signature and title of certifier.	Tola			290	c. License	number		1	29d. Date	signed (Monti	h, Day, Year)
•	M		> Holin	NU DO				P19	699			3	131/06	
-	3		30. Name and address of person who co	^ 42	1	1 6		- Str	ret	BIL	lto, n	1D	21201	
	Sta Registi		31. Date filed (Month, Day, Year)  APR 0 3 200	32/Registra	ar's Signat	ure de	when the			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				

			1 - For State Registrar	tate of Marylan		artment of tificate of		nd Men		ene 2.006	10:48
	Physici /Medic		1. Decedent's Name (First, Middle, Last) William James Ka	iser Jr.					late of Death Conth Ch	30 2006°	3. Time of Death 10:00a
	Examin		4a. Facility Name (If not institution, give stree Carroll Hospital Cen	t and number) ter			or Location of ninster	Death		4c. County of Deat Carrol	1
	Funeral Director		5. Social Security Number 6. Sex 141-14-1200 1X M	2□ F 7. Age (In yrs. 81	last birthday) Yrs.	If Under 1 Yea Months Days		4 Hrs. 8. D	Date of Birth Month, Day, 1 Ct 6 19	(ear) 9. Birth 224 NJ	nplace (State or Foreign untry)
	ehow	or	Usual Residence of Decedent  10a. State 10b. County  Md Carrol1		y, Town or Lo						10d. Inside City Limits
	with the N a or 28a-f Lbe notifi	Direct	10e. Street and Number 7401-26 Village Rd.			10f. Zip Code 21	784			g. Citizen of What Co JSA	untry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at ODGe.	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U Armed Forces? KYes 2 No WW Yes, Give Year or Dates:	ITT	Was Decedent of f Yes, specify Cu		in? (Specify Puerto Ricar	Yes or No- n, etc.)	14. Race - Ame Black, White Specify:Whi	a, etc.
Baltimore, Maryland 21215-0036	d within 72 hoi giene. ir than "naturi ir e Madical i	Completed	15. Decedent's Education (Specify only highest grade contemporary/Secondary (0-12)		(Give	dent's Usual Occ kind of work don DO NOT use retii Salesmal	e during most of red)	of working		6b. Kind of Business/ neumatic E	•
/land	uld be file Mental Hyg irked othe	To Be C	17. Father's Name <i>(First, Middle, Last)</i> William J Kaiser	.1		*		's Name <i>(Fin</i> Becker		aiden Sumame)	
Mary	and 2 sho alth and h		19a. Informant's Name/Relationship (Type, Mayne Kaiser (son)	Print)		ng Address <i>(Stree</i> 26 Villa				City or Town, State, 2 , Md 217	0.1
more	Pages 1 innent of He ant: If Item ary or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cren	sition (Name of matory or other pa y Cremat	tion 4	Date -2-06		oc. Location - City or kesville,	
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee  Pauge Haught	ferberst		.O. Box				cal Home & 1 21784	Chapel
	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition			er the mode of d					Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	_ \					
	scuted ind transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a conseq	Join	7,00	11180	se			
8760,	cate be executed physicien and the burial-transit	cal	resulting in death) Last	Due to (or as a conseq	uence of):						
P.O. Box 6	Physician: The law requires that the death certifica this certificate has been signed by the attending phy ral director, page 2 should be detached for use as it	Physician/Med	in the past 12 months?	f yes, outcome of pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown	Ideath 3	Ectopic pregnar Other (specify)	псу			23d. Date of deli Month	very Day Year
	uires that signed by id be deta	<u>م</u>	Part II. Other significant conditions contribu	uting to death but not res			given in Part I.		23e. Did toba	acco use contribute to	the cause of death?
Records,	To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should	Completed	Chance 1	32000	4.46	. S -			24a. Was an autopsy perform 1 🗌 Yes 2 l	prior to d	topsy findings available completion of cause of
Vita	sician: certific lirector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ital: 1 🗌 Inpatient 2 🗍	ER/Outpatien	it 3 DOA	)thor		eck only one	ice 6 Other (Spec	nihe)
Division of Vital	ding After	ation; To		8a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. In		28d.		v injury occurred	ary)
Divis	tal or Attendi s after death. al Director: A ed in by the fu	Certification;	3 Suicide 6 Could not be determined 2	8e. Ptace of Injury - At he building, etc. (Specif	ome, farm, str	eet, factory, offic	ө	28f. L	Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai				vestigation, in my	y opinion, death		t the time, dat	e and place, and due	to the cause(s)
)	Tot Com	Σ	29b. Signature and title of certifier	Long	h	29c. Lice	nse number	3 M	290	d. Date signed (Mont	n, Day, Year)
	2		30. Name and address of person who compt	eted cause of death (Iter	n 23a) (Type,	Print)	2301	1,0	Vesu	ille, Mi	2 3130% i
9.	Sta Registi		31. Date filed (Month, Day, Year)  APR 6 3 2006	32 Registrar's Signa	ature	all s					

			1 - For State Registrar	State of Marylai		artment of			giene Reg. No: 006	10149
	Physici		1. Decedent's Name (First, Middle, Last)  Michael			Kitko		2. Date of De Month March	Day Yea	
	/Medic Examin		4a. Fecility Name (If not institution, give s Johns Hopkins Bayvieu		er	0 1	or Location of D		4c. County of De	eath 0.1
	Funeral Director		5. Social Security Number 6. Sex	<del>-</del>	. last birthday) Yrs.	If Under 1 Ye Months Da		Hrs. 8. Date of Bir Min. (Month, Da NOV • 1		hirthplace (State or Foreign Country) aryland
	how		10a. State 10b. County		ity, Town or Lo	cation			-	10d. Inside City Limits
	the Ma	Director	Maryland Bal	timore		10f. Zip Cod	Edgeme:	re	10g. Citizen of What	1 ☐ Yes 2X No
	3a or	i Dir	7527 North Point	Poad		Tol. Zip Cod	21219		United Sta	•
036	2 should be filed within 72 hours after death with the Maryland and Menial Hygiene.  I and Menial Hygiene.  I amarked other than "naturel", or items 23s or 28s-f show sumatic event, the Medical Examination must be notilised at	by Funeral		12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent f Yes, specify (	of Hispanic Origin? Juban, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)		nerican Indian,
Maryland 21215-0036	within 72 ho one. Ithen "natur a Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	DO NOT use re	ne during most of tired)	working	16b. Kind of Busines	•
g 5	illed v Hygie other i	Be Co	8 Years 17. Father's Name (First, Middle, Last)		Fa.	ctory W		Name (First, Middle	American Maiden Sumame)	Can Corp.
ylan	should be and Mental marked o umatic eve	To B	Joseph Emory Ki				Mari	e V. Hole	winski	
Mar	ges 1 and 2 should tof Heelth and Mer i if item 27 ie marke or other traumatic		19a. Informant's Name/Relationship (Ty) Mrs. Catherine M.	(	1	•			er, City or Town, State	o, <i>Zip Code)</i> yland 21219
ē,	s 1 and 3 f Heelth Item 27 other tra		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date Edg	20c. Location - City	
E O	Pages nent of ant: if i		1  Burial 2 □ Cremation 3 □ R  □ Donation 5 □ Other (Specify)	emoval from State		natory or other ary Cem	etery 4/	4/2006	Dunda1k	, Maryland
Baltimore,	permit. Pages 1 and Department of Heeli Important: If item 2 any injury or other 2005.		21. Signature of Funeral Service License		22 D1	. Name and Aduda—Ruc	dress of Facility k Funera	1 Home of	Dundalk, : Maryland	Inc. 21222
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the deale cause on each line.	1 -	er the mode of	dying, such as can	diac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse		7, 0, 1, 0,				2 days
pt.	uted d ansit	Examiner	Sague tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse Liver fa	1					2 days
8760, -	ficate be executed physicien and s the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a conse						3 days
687	ntificate ng phy: as the	Aedic	JE SENALS.	3493,2						
P.O. Box	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	aldeath 3 [	Ectopic pregna Other (specify			23d. Date of o Month	delivery Day Year
rds, P	equires that en signed b ould be deta		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause	given in Part I.		obacco use contribute Yes 2 □ No 3 □	to the cause of death?  Probably 4 Junknown
Division of Vital Records,	. The law requisely the second page 2 should	Completed						24a. Was auto perfo 1 🗆 Yes	rmed / death	autopsy findings available o completion of cause of ? es 2 □ No
Zita Zita	ysician: Th iis certificete director, paç	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	7500		Other	Death (Check only		
ion of	ding Ph I. After th funeral	ation; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	28c. I	njury at Nork?		dence 6 ☐Other (S) how injury occurred	овсту)
Divis	tal or Attendrs effector: al Director: ed in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, str	eet, factory, off	сө	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital within 24 hours of the Funeral completely filled	Medical	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	occurred at the	e time, date and p ny opinion, death o	lace, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1/		11	ense number		29d. Date signed (Mo	
			> Jeffrey Meghter	W, M.D.		R	ES-000		March 3	31, 2006
	6		30. Name and address of person who co Or, Jeffrey Highfill	mpleted cause of death (Ite	m 23a) (Type,	Print)	Baltimore	e, MD 2	1224	
96.	Sta		31. Date filed (Month, Day, Year)	325 Registrar's Sign	ature	rathe d		/		
1 2	Registr	ar	APR 0 3 200	6 Barres A	J. 12	4				

ORIGINAL

			For State	State of Marylan		nent of Health an		21116	0151
	31		Registrar  1. Decedent's Name (First, Middle, Last,	) .	Cerun	cale of Dealif	2. Date of Death		3. Time of Death
	Physicia /Medic		Obadyah	Thomas	Lane	<u>ر</u>	March	27, 200	68:16 AM
)	Examin		4a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or Location of D	Death	4c. County of Dea	th
			5. Social Security Number 6. Sec	rial 1705P	last birthday) If	Doutine Inder 1 Year   If Under 24	Hrs. 8. Date of Birth	9 Riu	thplace (State or Foreign
	Funeral Director			M 2□F 54			Min. (Month, Pay	-51 Noi	th Carolina
	pu kana		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Locatio	2			10d. Inside City Limits
	Maryla febor	ļo	MD	B	altio				1 TYes 2 □ No
	n the	irec	10e. Street and Number		10	of. Zip Code	10	g. Citizen of What C	ountry?
	ath wil	Funeral Director	3629 Lyndal	e Alleve	ا ب	21213		USA	-
	items	-une	11. Marital Status  Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was I If Yes	Decedent of Hispanic Origin , specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Whi	
99	ours af	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1 🗆 Y	es 2 No Specify:		Specify: P	lack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. kther then "natural", or Iteme 23a or 28e-f ehow ont, the Medical Examination notified at	Completed	15. Decedent's Edu (Specify only highest grad		(Give kind	Usual Occupation of work done during most of	working 1	16b. Kind of Business	/Industry
12	withir iene. then	omo	Elementary/Secondary (0-12)	College (1-4or,5+)	So So	OT use retired)	21600	Salunt	ion Army
	be filed stal Hygi ed other event, I	Be C	17. Father's Name (First, Middle, Last)	1514 Degre		18 Mother's	Name (First, Middle, M	faiden Sumame)	d
yla	should bent marked umatic e	Tol	Warrenh	2N C		Pea	rlieh	Jillian	15
Maryland			19a. Informant's Name/Relationship (T)	Mo (II	3/- 2 G	dress (Street and Number of	or Hural Route Number, Roll	. N1D 2	1213
	es 1 and 2 of Health fitem 27 i		20a. Method of Disposition		Place of Disposition cemetery, cremator	(Name of	Date 2	20c. Location - City or	Town, State
Ē	Pages ment of ant: if it ury or o		1 ☐ Burial	Removal from State	cenhoun	Hrematory 4	-1-067	Saltino	CIMD
Baltimore,	permit. Pages Department of I Important: If it any injury or o		21. Signature of Funeral Service Licens	+ mo13	13 Va	ne a Address of Ficility	censo Fun	seral Se	ries
	40360		23a. Part1. Enter the disease, or compl	lications that caused the deat		amode of dving, such as cal	TA Ba	Uto MD	2 2 2 Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	1:16	TNEAN	tion		Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Due to (or as a conseq	quence of):	2111010	711011		
	Examiner	-	Soqueritiany hat conditions,	b. Due to (or as a conseq	vance of				
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence on).				
oʻ	exection and and trial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or as a conseq	quence of):				
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9	leeth certific attending p I for use as	//Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy			23d. Date of de	liven
. Box	deeth e atter	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		pic pregnancy er (specify)		Month	Day Year
P.O.	that the de led by the a detached f	Phys	9 Unknown	9□ Unknown					
ds,	signed be dei	by	Part II. Other significant conditions con	ntributing to death but not res	suiting in the underr	ring cause given in Part I.		/	to the cause of death?
COL	w require been si should t	jete				-	24a. Was ar	1 24b. Were a	utopsy findings available
Re	The lav	Completed					autopsy perform	red death?	utopsy findings available completion of cause of
/ita		Be	25. Was case referred to medical examiner?	I	,	1 -	Death (Check only one		
ð	Physician: r this certific ral director,	<b>T</b>	1 ☐ Yes 2 👿 No  27. Manngr of Death		28b. Time of		ng Home 5 Reside		ecify)
on	nding ath. r: Afte e fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury N	28c. Injury at Work?		.,,,	
Division of Vital Records,	l or Atte after des Directo I in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, f	actory, office	28f. Location (Str City or Town	eet and Number or R , State)	lural Route Number,
Ω	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy	pipiers. To the boot of multip	owlodge death are		lana and disable to		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one)	sician: To the best of my kno iner: On the basis of examina and manner stated.	ation and/or investig	urred at the time, date and p pation, in my opinion, death (	occurred at the time, da	use(s) and manner a ite and place, and du	is stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Mon	th, Dey, Year)
	15		'OX	jus		D0057	447 (	03/30	06
0	<i>L</i> .		30. Name and address of person who or	ompleted cause of death (Iter	m 23a) (Type, Print	Parki	vay D	aniel T	e to the cause(s)  th, Dey, Year)  CKIQY; MD
根	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature Ass	di)			
7	Registr	ar	APR 0 3 2	006 Decem	Jes Marie				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle 2 Date of Death 3. Time of Death **Physician** 1)549 2006 /Medical Name (If not institution, give street)

O1 E. Fayet and number 4c. County of Death 4b. City, Town, or Location of Death Examiner Bal 6. 6ex Under 1 Year Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) Funeral Months 115-42-9309 Usual Residence of Decedent Days Min 1 ☐ M 2 ☑ F Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. and If item 27 is marked other than "natural", or Itams 23s or 28s-f show 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits other traumatic avant, the Medical Examiner must be notified at 1 XYes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕽 No Specify: Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City permit. Pages 1 and 2: Department of Heelth at Important: If itam 27 is any injury or other trat 204. Location - City or Town, State od of Disposition ☐ driał 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 15ervi 23a. Partir Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final aMYOCAR DIAZ **Physician** -APCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for 1 ☐ Yes 21 ☐ No 9□ Unknown is been signed by the 2 should be detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 binknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificete 1 Yes 2 No a No 1 Yes **Division of Vital** To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. f Director: A 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) yd ni bellii 4 \( \text{Homicide} \) within 24 hours a To the Funeral I 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar NAWA

MOUT CEASAN

31. Date filed (Month, Day, Year)

GEAS AR

APR 0 3 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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32 Registrar's Signature

	2000		1 - For State Registrar	State of Ma		oartmer e <i>rtificat</i>			nd Mental F	lygiene Reg. No.	nnc.	10153
44	Physici /Medic		1. Decedent's Name (First, Middle, Last) Mary Elizabe		ear				2 Date of Month March		2006 2006	3. Time of Death 9:00p M
	Examir		4a. Facility Name (If not institution, give s 7301 Donald Court	street and number)		1	Town, or dbine	Location of	Death		County of De arroll	eath
<b>*</b>	Funeral Director		214 20 3320	7. Age	(In yrs. last birthda Yrs.	y) If Unde Months	Days	If Under 2 Hours	Min. 8. Date of (Month, Sept	Day, Year)	(	irthplace (State or Foreign Country)
	Maryland f ahow	ō	Usuel Residence of Decedent  10a. State 10b. County  Md Carroll		10c. City, Town or Woodbir							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the Na or 28s-	i Director	10e. Street and Number 7301 Donald Court				Code 797			10g. Citi	zen of What (	Country?
036	be filed within 72 hours after death with the Maryland stal Hygiene. ed other then "natural", or itema 23a or 28e-f ahow avent, tra Medical Exactinat must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		3. Was Dece If Yes, spe	cify Cubai	spanic Orig n, Mexican, Specify:	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify: Wh	
21215-0036	filed within 72 ho Hygiene. kther than "natur: ent, It a Me Jical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Gir	cedent's Usu ve kind of wo . DO NOT u lesper	ork done a se retired,	ition uring most	of working		nd of Busines jewelry	ŕ
Maryland	should be filed ind Mental Hygie is marked other umatic avent, II	To Be	17. Father's Name (First, Middle, Last) Edward G. Leishure	9					's Name (First, Mide Lanche Bro		Sumame)	
, Mar	d 2 sh th and th sm traum		19a. Informant's Name/Relationship (Typ. Tom Leizear (son)	pe, Print)	730	l Dona	1d C	t., Wo	or Rural Route Nur podbine, I			, Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Ri Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dis cemetery, ci Ivy Hill	position (Na. rematory or d L Ceme	me of other place tery	4-	Date -1-06		cation - City of ce1, Md	or Town, State
Balt	permit. Departr importa		21. Signature of Funeral Service License  Parge Hargette	ferkert					Haight Frykesville			& Chapel
Ì	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	cations that caused the cause on each line	9.		de of dying	, such as c	ardiac or respirator	arrest,		Approximate Interval Between Onset and Death
卷	/Medical Examiner		resulting in death)		consequence of):							
<b>V</b>	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		consequence of):							
8760,	ate be exi hysician a the burial:	Icai	d d	Due to (or as a	consequence of):							
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ds, P.O.	law requires that the d as been signed by the 2 should be detached	ρ	Part II. Other significant conditions con	itributing to death bu		underlying o	_	n in Part I.			se contribute	to the cause of death?
I Records,	The ate h page	Completed	Corovary	antery	disea	re			24a. W au pe 1 🗆 Yes	topsy formed?	24b. Were a prior to death?	autopsy findings available o completion of cause of
Vital	Physician: This certificate at director, p	Be	25. Was case referred to medical examiner?	laca itali			100		of Death Check on	v one)		
n of	ng Phys ter this neral dii	ation: To	1 Yes 2 Accident investigation	1 ☐ Inpation 28a. Date of Injury (Month, Day	t 2 ER/Outpati  / 28b. Time Injury		28c. Injury Work	4 🔲 (90)	sing Home 5 446 28d. Describ			pecify)
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, s (Specify)	street, factor	y, office		28f. Location City or	(Street and Town, State	d Number or I	Rural Route Number,
	ne Hospit n 24 hours ne Funera pletely fille	edicai (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	sician: To the best of ter: On the basis of and manner stat	examination and/or	ath occurred investigation	at the tim	e, date and inion, death	place, and due to the control occurred at the time	ne cause(s) e, date and	and manner a place, and du	as stated. ue to the cause(s)
)	To ti withii To th	Me	29b. Signature and title of certifier	WIN	~	290	License	number 9J02	my	29d. Dat	signed (Mor	nth, Day, Year)
	5		30. Name and address of person who con	mpleted cause of de	ath (Item 23a) (Typ	e, Print)	lain	· st	Westan	when	no	muy
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	Gosta	1			-		

			1 - State Registrar	State of Maryla	•	artmen rtificat			and M		Reg. No.	2006	n weath-rise as	0154
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Lorenzo Bascos	Lopez						2. Date of Dea Month MAR	Day	Yea 30, 20	r	me of Death
	Examin		4a. Facility Name (If not institution, give st Saint Joseph h		nter	4b. City,	Town, or	Location o	of Death	) Ti	4c.	County of De Ba	ath ltim(	ore
	Funeral Director		210 12 0110 11	M 2□F 7. Age (In yrs	s. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt Sept 5	h 192	9. E Ph	irthplace (S Country) 111pp	ines
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County Md Carrol1		ity, Town or Lo kesvill					-			1	ide City Limits
	with the 3a or 28a at be noti	al Direc	10e. Street and Number 2101 Harvest Farm	Road		10f. Zip					10g. Citi US	zen of What	Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If term 27 is marked other than "natural" or Iteme 23s or 28s-f show important: If term 27 is marked other than "natural" or Iteme 23s or 28s-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Deced If Yes, spec	**	ispanic Origin, Mexican	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)		14. Race - Ar Black, Wi Specify: W	nite, etc.	an,
Maryland 21215-0036	d within 72 ho piene. r than "natur the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usua kind of wo DO NOT us LCa1	rk done d se retired	during most il)	t of worki	ng		nd of Busines		
land :	uld be filed Mental Hyg irked othe itic avent,	To Be C	17. Father's Name (First, Middle, Last) Florentino Lopez							(First, Middle, a Basco		Sumame)		
, Mary	and 2 sho sath and ? n 27 ie ma ar trauma		19a. Informant's Name/Relationship (Typ JacqueLine Lopez	(spouse)						Sykesv				
Baltimore,	Pages 1 and the ment of He mut: If Item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State A	Place of Dispo cemetery, cre 11 Cour	natory or o	ther place cemat		4-3-(		Syke	cation - City sville	, Md	
Balt	Departition Depart		21. Signature of Funeral Service Licenses  Page Haight H		P.	2. Name an	d Addres	ss of Facility 95 Syl	yHaig kesv:	ght Fun ille, M	era1 d 21	Home 784	& Cha	pel
	Attending Physician: The law requires that the death certificate be executed to the form of the form o	dical Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list curditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consection of the consection)  Due to (or as a consection of the consection)	NCEPHA equence of): ARREST equence of):	ALOPA	THY						Interv	ximate al Between and Death
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rds, P	quires that n signed b uld be deta	by	Part II. Dther significant conditions cont	ributing to death but not re	esulting in the u	inderlying c	ause givi	en in Part I.		23e. Did to		se contribute No 3□		e of death?
al Records,	n: The law require icete hes been sij r, page 2 should b	Completed							_		sy rmed? 2 12 No	24b. Were prior to death	o completio	dings available n of cause of
† <	nysiciar nis certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DC	Oth	05		<i>(Check only o</i> ne 5 ☐ Resid		3 □Other (S <sub>i</sub>	pecify)	
Division of Vital	inding Plath. ath. ir: After the		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. ate of Injury (Month, Day Year)	28b. Time o Injury	f 2	8c. Injun Worl 1 ☐	yat k? Yes 2 □ h		28d. Describe h	ow injur	y occurred		
<u>S</u>	in the	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory	, office			28f. Location (5 City or Tov			Rural Route	Number,
	the Hospitel hin 24 hours a the Funeral i npletely filled	Medical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin	ician: To the best of my kr er: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred vestigation	at the tin , in my o	ne, date and pinion, deat	d place, a th occurre	and due to the ead at the time,	cause(s) date and	and manner place, and d	as stated. ue to the ca	use(s)
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	4		30. Name and address of person who don				ากม	SON I	MODY	(LAND	T1 T1	71.4.		
3	Sta Registr		31. Date filed (Maph Day, Yar) 2006	22 Registrar's Sig	ature 60		1 753 8.4	and had I N	- 13.31.\	1 Jun 1 73 74 hd	has de less			

	•	State of Man	yland / Depa		lealth and M	ental Hygie	•	0155
Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Last)  EDWARD V  4a. Facility Name (If not institution, give street and number)  DALT MORE VA MEDICAL C	LEONAR enter	BALY	Location of Death		Day Year 2006  4c. County of Death N/A	
Funeral Director		220-12-5868 1 M 2 □ F 82  Usual Residence of Decedent	In yrs. last birthday) Yrs.  Oc. City, Town or Lo	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay Aug 8 1		place (State or Foreign ntry)  10d. Inside City Limits  1 □ Yes 2 🛣 No
be filed within 72 hours after death with the Maryland tat Hygiene. Ital Hygiene dother then "neturel", or iteme 23s or 28s-f show event, the Madical Examiner must be nutified at	Funeral Director	10e. Street and Number 3732 Wards Chapel Road		10f. Zip Code 21104			g. Citizen of What Cou USA	ntry?
nours after de urel', or itema il Examinar m	þ	11. Marital Status  1	WWII	1 ☐ Yes 2 ሺ No	lispanic Origin? (Spe an, Mexican, Puerto Specify:		14. Race - Amen Black, White, Specify: Whi	etc. ite
	Be Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  11  17. Father's Name (First, Middle, Last)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of worki	ng	agricultu	
	To Be	Edward V. Leonard Sr.  19a. Informant's Name/Relationship (Type, Print)			Alice E.	Hofeset	ter City or Town, State, Zij	
pernitt. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marked any rolury or other traumatic pages.		George Leonard (brother)  20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	20b. Place of Dispo cemetery, crea Wards Cha	osition (Name of matory or other place apel Cem.	4-4-0	Oate 20	tsville, Mo Do.Location-City or T arriottsvil ral Home &	own, State 11e, Md
Physician /Medical Examiner	cal Examiner		e death. Do not en		95 Sykesv		ıt,	Approximate Interval Between Onset and Death
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. <b>5</b> # <b>5</b> €	al Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of triury building, etc. (	(Specify)			City or Town,		
To the Hospital within 24 hours a To the Funeral completely filled	Medical	(Check only 2 Medical Examiner: On the basis of eyone) and manner state:	xamination and/or in d.	nvestigation, in my o	opinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
Sta Registr		Homina Thomas MD  31. Date filed (Month, Day, Year)  APR 3 2006  32. Registrar's	s Signatura	10NG	eene St	Reet BA	13/30/06 Himure, M	1) 21201

			For State Registrar	State of Ma	aryland .		artment of tificate o				giene Reg No.	06	10156
	Physici	30	1. Decedent's Name (First, Middle,	Lou k	/ 5 N.E	/				2. Date of Dea Month	ath Day	Year	3. Time of Death
	/Medic		JAMES		CONE	. ~				03	20	2006	3:31P M
	Examin	er	4a. Facility Name (If not institution, g		oi+		4b. City, Town	or Location umbia				unty of Death vard C	
4 %			Howard County C		e (In yrs. last	hirthday)	If Under 1 Ye		der 24 Hrs.	8. Date of Birtl			place (State or Foreign
	Funeral Director		214-54-7170	12M 2□F 54		Yrs.	Months Day			(Month, Da) Feb. 2	v, Year)	Cou	yland
		Ì	Usual Residence of Decedent							100. 2	3,133		
	how	_	10a. State 10b. County		10c. City, T	own or Lo	cation	37 - I- I					10d. Inside City Limits 1 ☐ Yes 2 🖾No
	Be-1	cto		Ltimore					inghar				
	with th	吉	10e. Street and Number				10f. Zip Code	Э	01006			of What Cou	ľ
	s 23	era	8522 Hydra Lar	12. Was Decedent	Ever in II S	13 1	Was Decedent of	M Hispanic	21236 Origin? (Spe	orify Yes or No-		ted St. Race - Amer	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any figury or other traumatic event. The Medical Exercise count is a collided at anne.	/ Funeral Director	1 ☐ Never Married 2 🗖 Married	Armed Forces?  1 ⊠Yes 2 □ 1	No		Was Decedent of fYes, specify C 1 ☐ Yes 2 🔯 N			Rican, etc.)		Black, White	
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	Vietn	am							White
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lan	Aenta Aenta rked tlc ev	To B	Victor C. Loul	conen				N	Martha	J. Hei	del		
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Baltimore,	ges 1 it of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		cem	etery, cren	sition (Name of natory or other p	olace)	1	ate		on - City or T	
Ħ	it. Pa		4 ☐ Donation 5 ☐ Other (Spe 21. Signatury of uneral Service Lie		Garr		Forest  . Name and Add			/29/200	6 Ow:	ings M	ills, MD
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			23a. Part1. Enter the disease, or shock, or heart fallure. List or	omplications that caused by one cause on each li	d the death. I	Do not ent	er the mode of o	tying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between
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100	/Medical Examiner		resulting in death)										
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P.0	that the	Ph	Part II. Other significant condition	s contributing to death b	out not resulting	na in the u	nderlying cause	given in Pa	art I.	23e. Did to	obacco use	contribute to	the cause of death?
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00	s been si should	Completed								24a. Was		4b. Were aut	opsy findings available
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<u></u>	Physician: rthis certific ral director.	ToE	examiner? 1 Tes 2 No	Hospital: 1   Inpatie	ent 2 ER	VOutpatier	IL JUDON		Nursing Hor	me 5 Resid	dence 6	Other (Spec	ify)
0	ding Ph th. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ly Year) 28	Bb. Time of Injury		njury at Work?		28d. Describe h	now injury o	ccurred	
sio	r Attending er death. rector: Alter by the funer	catl	2 Accident investiga 3 Suicide 6 Could no	t he				☐Yes 2		206 1	74 4 a of 8		-10
Division	after of Direct of in by	Certification:	4 Homicide determin	ed 28e. Place of inj	iury - At nome tc. <i>(Specify)</i>	e, tarm, str	eet, factory, offi	ce		City or Tox	vn, State)	umber or Au	ral Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C		Physician: To the best xaminer: On the basis o and manner st	of examination								
	omple	Me	29b. Signature and title of certifier				29c. Lic	ense numb	er		29d. Date s	igned (Month	, Day, Year)
	->F0		Jan	MI)			$\mathcal{L}$	005	3709		3-	20-	2004
5	+19		30. Name and address of person w	ho completed cause of c	death (Item 2:	3a) (Type, a//an	Print)	lan	57	E #	2/0	Bowie	e MD 20715
	Sta		31. Date filed (Month, Day, Year)	2006 32 Aegistr	rar's Signatur	· /	ale	1					
	Registr	ar	APR 0 3	ZUUD Jakos	20 10	17							

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Registrar

APR 0 3 2006

Loughy, Raymon & Baltimore, Maryland 21215-0036

			Please T	ype or Print State of Mar							•		_	<b>)</b> .		
			1 - For State Registrar	Olate of Imal	ylaria	•			Death		-	Reg. No	DOC		101	59
	- · · ·		Decedent's Name (First, Middle, Last)							2	. Date of De	ath Da	y Ye	ar.	3. Time of I	
	Physici: /Medic		Raymond D.	Loughr	<u>y</u>						avch	31	201	علا	12,50	AM
	Examin	er	4a. Fecility Name (If not institution, give s Baltimore Washing		al Ce	nter	4b. City,		Location of en But			4c.	County of D		ndel	
	Funeral Director		Social Security Number		(In yrs. lasi	t birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	Min.	. Date of Bir (Month, Da UIY	th Year)	941	Birthpla Count	ace (State or ry) MD	Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	Fown or Loc	cation							10	d. Inside Cit	y Limits
	a Mary la-f sho liffed a	ctor	Maryland Anne Arı	ındel					Pasad	ena					1 🗆 Yes	2 <b>X</b> No
	with the a or 26	Director	10e. Street and Number 756 213th Street				10f. Zij	Code	21122			10g. Cit	tizen of What	Count	ry?	
	ns 23	Funerai		2. Was Decedent Ev	er in U.S.	13. V	Vas Dece				fy Yes or No	)-	14. Race - A			
920	ba filed within 72 hours after death with the Maryland that Hyglene. ad other than "natural", or Itams 23a or 28a-f show event, it to Madral Examinar rout be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: 1	959- 961				n, Mexican Specify:	, Puerto Ri	can, etc.)		Black, V Specify:	1	ite	
15-0	n 72 hc natur	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	1	16a. Deced (Give	ent's Usu kind of wo	al Occupa ork done d	ation furing most	of working		16b. K	ind of Busine	ss/Ind	ustry	
212	a filed within al Hygiene. other than '	omo	Elementary/Secondary (0-12)	College (1-4or 5+)	)			k Dr				No	rth Ba	уDi	strib	uting
nd	ba file ital Hy id othe	Be	17. Father's Name (First, Middle, Last) Clifford Loud	zhav					18. Mothe		First, Middle Shij		Sumame)			
Maryland 21215-0036	should and Mer smarke	ဥ	Clifford Loughant's Name/Relationship (Ty) Lenora M. Loughry						and Numbe	r or Rural F		er, City o	or Town, Star 21122	te, Zip	Code)	
	s 1 and 2 if Health Item 27		20a. Method of Disposition		20b, Plac	e of Dispos	sition (Na	me of		pri Pat	7		ocation - City	or Tov	wn, State	
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item eny injury or otha		1 ☑ Burial 2 ☐ Cremation 3 ☐ R  '4 ☐ Donation 5 ☐ Other (Specify)			n Have	en Ce	emete	ry	200	6		n Burn			
Ball	permit. F Departme Importar eny injur		21. Signatur of Funeral Service Citeme			22			ss of Facility untai				uneral na, MD			Α.
STATE OF THE PERSON NAMED IN	Pnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a	tat	ic E	er the mo	de of dyin	g, such as	cardiac or r		rrest,			Approximate Interval Betv Onset and D	veen
	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequer	nce of):										
60,	be executed ician and burial-transit	ai Examine	that initiated events resulting in death) Last	Due to (or as a	consequer	nce of):										
9289	rtificate being physicial as the bur	ledica	d													
P.O. Box	The law requires that the death certificate be ste has been signed by the attending physicis page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	☐ Fetal de	ath 3	Ectopic p Other (s	regnancy pecify)					23d. Date of Month		-	ear
	es that igned by be deta	by Pt	Part II. Other significant conditions con	tributing to death but	not resulti	ng in the ur	nderlying	cause give	en in Part I.				use contribut			
ord	w require baen si should l	eted									24a. Was	Yes 2		Proba	sy findings a	nknown
of Vital Records,	The law cate has page 2 s	Completed									auto		prior deat	to con	pletion of ca	use of
Vita	ician: certific ector.	Be	25. Was case referred medical examiner?	ospital:				Othe	00		Check only					
	Phys this ral dir	tion: To	27. Moler of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day		Outpation  Bb. Time of Injury		28c. Injun Worl	4 LI NU	28	e 5 Resi d. Describe		6 Other (	Specify	)	
Division	or Atten fter deat diractor: in by the	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Place of Injur building, etc.	y - At home (Specify)	e, farm, str	eet, factor				f. Location ( City or To		nd Number o e)	r Rurai	Route Num	ber,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical C		sician: To the best of her: On the basis of e and manner state	examination											
	To the Within To the comple	Med	29b. Signature and title of certifier	` ^	L M	MD	29	c. License	e number			29d. Da	te signed (N	fonth, L	Day, Year)	
) _	16		Meory C.				Dries\	NY	1760	,		110	signed (M	> ( ) .	KUVO	
5	10		George E. W	mpleted cause of dea	M.D	30	1 H	OSPA	ted 1	DVIV	e, Gli	en E	Surn	e, I	TV. 2	106)
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 3 20	32 Negistrar	s Signatur	· As	entil	,								

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Hanora M. McCormick 3/19/2006 6:10am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 1517 Fast Fort Avenue Baltimore City Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/21/1932 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 73 Yrs **Funeral** Months Days Hours 1 □ M 28734F 218-28-9585 Yrs MD Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b County 10a State ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar rust be rigitled at Baltimore City MD N/A 1√2¥es 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1517 E. Fort Avenue 21230 USA Completed by Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Iter ury or other traumatic event. Its Medical Examinat ☐ Yes 2 **X**XX f Yes. Give Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: White Specify: Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 0 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Honora Thornton Richard P. Hughes, Sr. ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Thomas G. McCormick / Husband 1517 East Fort Avenue, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Figure 1 in the any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 3/22/2006 Baltimore MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. Victor P. Doda, Jr. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer-2 months **Physician** disease or condition resulting in death) ) ma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknow ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performe 1 Yes 2**XX**Io 1 ☐ Yes XXXo Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗙 🗙 🕶 o this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 | Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) within 2 ro the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 20, 2006 DO051776 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leans Street Baltimore Maryland 21231 M1)16500 d 31. Date filed (Month, Day, Year) egistrar's Signature State APR 0 3 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of M	arylan		artment rtificate			and M		and the same	006	* Alabaya	62
			Registrar  1. Decedent's Name (First, Middle, I	l ast)		Cei	lilicale	OIL	Jeani		2. Date of De	Reg. No.**	000	3. Time of D	Death
	Physicia	an									Month March	Day	2006	4:30	
,	/Medic Examin	-	Anna Mary Me				4b. City, T	rown, or	Location o	of Death	Har CH		ounty of Death	1.30	
	Examin	eı	Baltimore Was			Ctr	Gle	en E	Burni	ie		Ar	ne Ar	undel	
	Funeral			5. Sex 7. Ag		last birthday)	If Under 1	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt	th v. Year)	9. Birth	place (State or I	Foreign
	Director		214-80-8885	1□M 2 <b>M</b> F	95	Yrs.	Nontrio	50,0	1100.0		12/01	/191	0	MD	
	w w	}	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City	Limits
	daryii f eho	0	MD Anne	Arundel	Pa	saden	12							1 ☐ Yes 2	2 <b>™</b> No
	the t	Directo	10e. Street and Number	ar aracı	1 4	<u> </u>	10f. Zip (	Code				10g. Citize	n of What Cou	ntry?	
	3a or	Ö	7619 Beach D	rive			21	122				U.S.	Α.		
	death	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decede	ent of Hi	spanic Orig	gin? (Sp	ecify Yes or No	- 14.	Race - Ameri Black, White,		
စ္	or its	F	1 Never Married 2 Married	d 1 ☐ Yes 2 🕱			1 🗆 Yes 2	347 "	Specify:	,		S	pecify: Whi		
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Medical Examiner must be notified at	d by	3 ₩ Widowed 4 Divorced	Year or Dates:											
5	"nat	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual kind of work DO NOT use	k done a e retired	ation during most ')	t of work	ing	166. Kind	of Business/Ir	dustry	
7	withi	mo	Elementary/Secondary (0·12)	College (1-4or	5+)		emak					Own	Home		
0	illed Hygi other	Be C	17. Father's Name (First, Middle, La	ast)					18. Mothe	r's Nam	e (First, Middle,	Maiden Su	ımame)		
<u>a</u>	Aental rked o	To B	Henry J. Wend	del					Ma	tti	e Have	n			
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "natural", or iteme 23e or 28a-f show eumatic event, the Medical Examinar must be notified at		19a. Informant's Name/Relationship	<sup>р (Турө, Print)</sup> Gran	d-	19b. Maili	ng Address	(Street a	and Numbe	r or Rur	al Route Numbe	er, City or T	own, State, Zij	Code)	
≥ .	and and m 27		Darlene Arrin	gton/Daug	hter				Driv						
ore	Jes 1 If ite		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3	3 □Removal from State	C	lace of Dispo emetery, cre	matory or oti	her place			Date		tion - City or T		
altimore,	t. Pactiment:		4 Donation 5 Other (Spe	All Transfer	Но	ly Ci					30/06		timore		D.3
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other treumatic es		21. Signature of the meral Service Li	pensee							J.Gonc ve, Pa				
			23a. Part1. Enter the disease, or co	omplications that cause	d the death								iia, iii	Approximate	
	Diam's face		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each I	ine.				11					Interval Betwee Onset and De	
1	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	Myoca do:	ardia		Me	41 Clu	^)				
	Examiner				,	9			·						
	n =	ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	uence of):									
	acuter ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с.											
760,	cien s	Ê	resulting in doutily East	Due to (or as	a consequ	uence or):									
ന	death certificate be executed e ettending physicien and of for use as the burial-transit	dical		d			_	_							
79 ×	certif Iding	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								230	d. Date of deliv	ery	
ă	death e etter	ciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			□Ectopic pre □ Other (spe						Month	Day Ye	ar
P.O. Box	t the by the tache	hys	9 Unknown	9□ Unknown											
	Attending Physician: The law requires that the ir death. It death. ector: After this certificete has been signed by the by the funeral director. page 2 should be detache.	d by Physician/Med	Part II. Other significant condition	s contributing to death t	out not rest	ulting in the u	inderlying ca	ause give	en in Part I.		23e. Did t			he cause of dea bably 4, ⊟Un	
Sor	A requ	Completed				-					24a. Was	an :	24b. Were auto	opsy findings av	vailable
æ	he la e has age 2	mo D			-							rmed?	prior to co death? 1 \( \text{Yes}	mpletion of cau 2□ No	use of
ta	en: T	BeC	25. Was case referred to medical						26. Place	of Deat	1 ☐ Yes h (Check only o	2 No	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2L1N0	
<u> </u>	ysici is cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1   Inpati	ent 2 🗷	ER/Outpatie	nt 3 DO	A Othe	er: 4 □ Nu	ırsing Ho	me 5 Resi	dence 6 [	Other (Speci	fy)	
Division of Vital Records,	ling Pt t. After th Uneral		27. Manner of Death  1. Natural 5 Pending		ay Year)	28b. Time o Injury	of 28	8c. Injury Work	/at k? Yes 2 □	No	28d. Describe	how injury o	occurred		
<u> S</u>	death death stor: / the	icat	2 Accident investiga 3 Suicide 6 Could no	ot be Geo Place of le	iury - At ho	ome farm st			103 2		28f. Location (	Street and I	Number or Rur	al Route Numbe	er.
<u>≥</u>	s after s after of Dire	Certification:	4 Homicide determin	building, e	tc. (Specify	y)	, , , ,	,			City or To				
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificete has been signed by the ettending phy completely filled in by the funeral director, page 2 should be detached for use as the	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physicien: To the best xaminer: On the basis of and manner s	of examina	wledge, deal tion and/or in	th occurred anvestigation,	at the tim in my op	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) ar date and p	nd manner as s lace, and due t	stated. to the cause(s)	
	To the To the Comp	Me	29b. Signature and title of certifier,	11 -	MA		29c.		e number	<u></u>		3	signed (Month,		
)	1		* HEV					D);	504	10		3/1	25/06		
i	0		30. Name and address of person w	tho completed cause of	death (Item	23a) (Type	Print)	100	2/14.4	Par	rol euro	MD	9112-2		
	Sta	to	31. Date filed (Month, Day, Year)	ATIUM,	rar's Signa	iture	me roug	(1) (	my,	IVAC	w curl	- 4	XIII		
	Registi			3 2006	spen .	Rittle	parti	,							

			1 - For State Registrar	State of M	laryland /	Depa <i>Ce</i>	artment of H tificate of L	ealth a Death	and Me		ene g. No.	306	10163
	Physici /Medio		Decedent's Name (First, Middle, La Rose	ist)	В.		Mitche:	11		2. Date of Death Month NANCH	Day 29	2006	3. Time of Death
	Examir		4a. Facility Name (If not institution, given University Spectors)	iality	r)			imore				ounty of Death	
	Funeral Director			Sex 7. A 1 □ M 2/□ F	ige (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under: Hours	Min.	B. Date of Birth (Month, Day, 6-25-2		Coun	lace (State or Foreign try)  Va.
	Maryland -I show	tor	10a. State 10b. County Md. NA		10c. City, Tov		cation L <b>more</b>					11	0d. Inside City Limits 1X Yes 2 □ No
	h with the 3a or 28a at be noti	al Director	10e. Street and Number 1719 McKean Ave	•			10f. Zip Code 212	217		10	g. Citize	n of What Coun USA	try?
920	72 hours after death with the Maryland netural', or Items 23a or 28a-1 show dical Evantrat rout be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceder Armed Forces 1 Tyes 3/ If Yes, Give Year or Dates	?	- 1	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☆ No	spanic Orig n, Mexican Specify:	gin? (Speci , Puerto Ri	ify Yes or No- ican, etc.)		. Race - Americ Black, White, o	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. Item 27 is marked other than "netural", or items 23a or 28a-1 show other traumetic event. Ir a Medical Exertir ar result be notified as	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 9th grade			(Give	dent's Usual Occupa kind of work done of DO NOT use retired od Service	during most )	t of working	9		of Business/Ind	Services
and	12 should be filled within h and Mental Hyglene. 7 Is marked other than "traumetic event, to a Mes	To Be C	17. Father's Name (First, Middle, Last Matthew	)	Mont	ier		18. Mothe		(First, Middle, N	laiden Su	<sub>Imame)</sub> Mont	ier
Maryland	and 2 shoul salth and Me n 27 Is marl	Ė	19a. Informant's Name/Relationship (Elaine White-Spe		iece 19		ng Address (Street a 26 Harlem			Route Number, timore,			
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 any Injury or other tra <u>once</u> .		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy)	cemete	ery, crei g Me	sition (Name of natory or other place)  m. Park		Da 4-5-	1		tion - City or To Idallsto	wn, Md.
Bal	Depa Impo any Ir once		21. Signature of Funeral Service Lice	- A Les		-	Name and Addres	. Eas	t			eth Ave	21202
	Physician /Medical Examiner	er	23a. Pari 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2,	a	ine.	of):		g, such as	cardiac or	respiratory arre	st,	T	Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or a	s a consequence	of):							
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No		2 Fetal deat at time of death		Ectopic pregnancy Other (specify)				236	d. Date of delive Month	ny Day Year
ds, P.	uires that signed b id be deta	by	Part II. Other significant conditions	contributing to death		in the u	nderlying cause give	en in Part I.			acco use		ably 4 Chknown
of Vital Records,	The law require ate has been sig bage 2 should b	Completed	Jun Bro	E						24a. Was ar autopsy perform 1 Yes 2	,	prior to cor death?	psy findings available inpletion of cause of 2 No
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	Certification; To Be C	25. Was case referred to medical examiner?  1 Yes 2 Yolo 27. Manner of Death	28e. Place of I	jury 28b. Pay Year)	Time o Injury	28c. Injury Wark	er: 4□ Nu ⁄at	rsing Home 28 No	(Check only one e 5 Reside	nce 6 [ w injury o	occurred	r) I Route Number,
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**ORIGINAL** 

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	hours after death with the Maryland tural', or Iteme 23a or 28e-f show al Examiner must be notified at		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limits
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	Examiner			UNDIFF	ERENTIA	TED	Souf	MOVS	SCE	LI HEA	D A	UD NEC	K CANCER
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Year A M **Physician** John J. O'hare 2 3 BUCG. MArch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIME: C If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. SAINT AGNES HEALTHCARE NA 8. Date of Birth (Month, Day, Year) May 28,1957 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F 219-62-2643 48 Months Director Baltimore MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic avent, Itin Mudical Examment at Itinitied at another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel 1 ☐ Yes 2 No Cambrills Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2409 Arapaho Way 21054 ITSA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 UNK. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John J. O'Hare Sr. Irene S. Kuciej ္ဝ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2409 Arapaho Way Cambrills, MD 21054 Karen J.McCarthy/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 24, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore MD 21230 4 □ Donation 5 □ Other (Specify) 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Ave Baltimore MD 21230 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Havance Nasopharyngea Carcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Drúnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Pancreatitis this certificate hes autopsy 1 Yes 2 X No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ❤️No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. \ To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) MO D0053312 March 23, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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32 Registrar's Signature

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31. Date filed (Month, Day,

Avenue:

			For State		aryland / Dep	artment of H	ealth and N	-	•	10166
			1 State Registrar  1. Decedent's Name (First, Middle, Las	×1	Ce	rtificate of L	Jeath	Re 2. Date of Death	g: No. U U	3. Time of Death
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		•	Levindale Ger:	iatric Ce	enter		ore Cit	У		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign untry)
	Director		220-18-2742 Usual Residence of Decedent		10			April	19,1927	MD
	how		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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	0,		som 10	L. wists	town	D00	6332	7	3/31/0	6
11	) -X		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)				
			GIZAW WOZ  31. Date filed (Month, Day, Year)	DE HIWL	7, 2434	w, isel	Vedere	Ave, B	altimore	MD 21215
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Funeral Director		1	Sex 7. / 1 <b>X</b> M 2 ☐ F	Age (In yrs. last		If Under Months		If Under 24 Hours	Min.	8. Date of Bir (Month, Da DZ · ZC	th ay, Year) 0 · 1978	9. Bin Co	thplace (State or Foreign
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Definition of your permit. Pages 1 ar Department of Heal mportant: if item 3 any injury or other page.		20a. Method of Disposition 1 🗆 Burial 2 🗷 Cremation 3 🗓		20b. Place ceme	of Dispo	sition (Nam	e of her place	) i	Da	ite	20c. Location	on - City or	Town, State
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the c	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1 ☐ Live birth	2 □ Fetal dea at time of death		Ectopic pre Other (spe						Date of deli Month	very Day Year
8 g a	۾ ا	Part II. Other significant conditions of	contributing to death	but not resulting	in the ur	derlying ca	use giver	n in Part I.			obacco use co		the cause of death?
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ttendii death. stor: A	ertification;	2 Accident investigation 3 Suicide 6 Could not b	3-13	-06 1	0.4	DM	1 🗆 Y	es 2 No		Sup	ject ·	shot	
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To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completaly filled in by the funeral director.	ledical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysicien: To the best niner: On the basis and manner s	ot examination a	ne death	occurred at	t the time	, date and pl nion, death o	lace, and	d due to the d at the time, d	cause(s) and date and place	manner as e, and due	10
To t com	Σ	29b. Signature and title of certifier	1 0m 3	R	01	29c.	O.C	number .M.E		2	29d. Date sign MARCH		. <i>Day, Year)</i> 2006
4		30 Name and address of person who	completed cause of	1			ידוקדי	DATET	MODE.	MADST	ANTO O1	201	
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	Funeral			Sex M 2□F	7. Age (In yrs.	. last birthday)	If Unde	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date (Mo	e of Birth	Year)	9.	Birthpl Count	ace (State or	Foreign
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₹ Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic svant. If a Medical Examinar must be notified at once.		21. Signi rure of Funeral Service Lice	Vict	or Doc	da Cff	arre	d Addre	ss of Sellie	even	s F	une	ral	Hom	e,	Inc.	
ш	205#3		1000		>	1	501	Eas	t Foi	rt A	ver	iue,	Ва	ltim	ore	MD21	1230
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that o one cause on e	caused the dea each line.	th. Do not ente	er the mo	de of dyir	ng, such as	cardiac o	respira	atory arre	est,			Approximate Interval Betwo Onset and De	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		shac	an	es	<del></del>			<u>-</u>				io me	-γλ_
	Examiner			Due to	(or as a consec	quence of);	11.	4	Fai	0	_	00	10			10	
		Jer	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a ø nsec	quence of):	416	25/1/2	17	lun		2 -	< X1	2 /1		1 car	)
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≥ u	Attending r death. ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investigation		of Injury th, Day Year)	Injury	м	28c. Injun Wor	k? Yes 2 □ N		ou. De	SCHOOL HO	w injury i	occurred			
∭ Divisio	Attendi	Hica	3 Suicide 6 Could not to determined	28e. Place	of Injury - At h	ome, larm, stre	et, lactor				8l. Loca	ation (St	reet and	Number or	Rural	Route Numbe	ə <i>r</i> ,
ā	호텔들도	Certification:	→ □ HOMICION	buildi	ng, etc. <i>(Specil</i>	(Y)					City	or Town	, State)				
	Hospital		29a. Certifier 1 Certifying P	miner: On the bi	asis of examina	owledge, death	occurred	at the tin	ne, date and	d place, a	nd due	to the ca	iuse(s) ai	nd manner	as sta	ted.	
	vithin 24	Medicai	one) 29b. Signature and title of certifier	and mani	ner stated.				e number		(*16						
	8 7 ¥ 7	_	2 1	9								25	Ju. Date:	signed (Mo	onan, D	ay, rear)	
	-5		30. Name and address of person	mplated as	77 - ~~	n 232) (Time 1	Print'	1 8	86	7		-	3 [ 1	31	20	00	
4	5 '						, <b>N</b> D .	GAL	4 500	42		814	17	a		7	
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	_	For Stata Registrar	State of M		nd / Dep	artme	nt of H			tal Hyg		06	101	69	
Physician	1	Decedent's Name (First, Middle, L Roland	ast)	Α.	Pie	erce			N	ate of Deat Ionth	Day	Year		of Death	
/Medica Examine		4a. Facility Name (If not institution, g. 521 E. 38th Str		r)		4b. City	Town, or Balti	Location of De	eath 3	3	4c. Cc	2006 ounty of Death NA	6:0	ioa ™	
Funeral Director		223-26-2190	Sex 7. A 1[X]M 2□ F	ige (In yrs	. last birthday) Yrs.	If Unde Months	Days	If Under 24 H Hours M	in. 8. D	ate of Birth Month, Day, 9–10	Year) <b>-26</b>	9. Birth Cou	nplace (State untry) Va.	or Foreign	
and		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside	City Limits	
Maryl sho	5	Md.		E	altimo:	re								s 2 No	
offer death with the Market services 23 or 28a-f since the market for collised to be rectified.		10e. Street and Number 2054 Kennedy Ave				10f. Zi	p Code 212	1 Ω		10		n of What Cou	untry?		
Jeath Interes	בום	11. Marital Status	12. Was Deceden Armed Forces	t Ever in l	J.S. 13.	Was Dece			(Specify )	(es or No-		Race - Amer	ican Indian		
permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exami are must be notified at any injury or other traumatic event, the Medical Exami are must be notified at 2008.	29 7	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 SYes 2 If Yes, Give Year or Dates	] No		If Yes, spi 1 ☐ Yes		spanic Origin? n, Mexican, Pu Specify:	erto Rican	i, etc.)	!	Black, White	, etc. lack		
natural dical	מנט	15. Decedent's E (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usu kind of w	al Occupa	ition Juring most of v	working	1	6b. Kind	of Business/li	ndustry	Co.	
ed within 72 hours e ygiene.  Ygiene.  Ter than "natural", of the Medical Exam	2	Elementary/Secondary (0-12) 12th grade	College (1-4or	5+)	1			nt Oper			McC	lean C	ontrac		
2 should be filed within and Mental Hygiene ls marked other than aumatic event, the Market To Re Common	ם	17. Father's Name (First, Middle, Las Frank	t)	Pier	ce			18. Mother's N		t, Middle, M	laiden Su		rles		
1 and 2 sho Health and N em 27 is ma ther trauma	- )	19a. Informant's Name/Relationship Diane Pierce	(Type, Print) Daugl	nter				nd Number or treet,				own, State, Zi 2121	_		
Pages 1 nent of He ant: If iten ary or oth		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 [			Place of Dispo cemetery, crei	natory or	other place		Date			ion - City or T			
permit. Page Department of Important: if eny injury or once.	4 Donation 5 Other (Specify) Mt. Carmel Cem. 4-4											undalk, Md. ltimore, Md. . North Ave.		21202	
Sharing the burial-transit to the burial-transit to the burial-transit to the burial Examiner to the burial Examin			disease or condition resulting in death)  Sequentially list conditions, and the cause of the cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	i a nonte	(uence of):	C 2/L								
The law requires that the death certificate be exwate has been signed by the ettending physicien a cage 2 should be detached for use as the burial-completed by Physician/Medical Excompleted by Physician/Medical Ex		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fet	al death 3	Ectopic p Other (s					23d	. Date of deliv Month	ery Day	Year	
w requires that been signed should be dele		Part II. Other significant conditions	contributing to death i	but not re:	sulting in the u	nderlying	cause give	n in Part I.	2		cco use	contribute to t	the cause of		
									-	4a. Was an autopsy perform Yes 2		4b. Were auto prior to co death? 1 \(\sum Yes\)	mpletion of	available cause of	
Physician: this certific ral director,		25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of D					Davi	ghters	
Attending Physic death.  • ctor: Atter this by the funeral diffication: To	4	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju		ER/Outpatien 28b. Time of Injury		28c. Injury Work	at Nursing		Resider		Other (Special		5.71	
ral or Attending P rs after death. al Director: After led in by the funera Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)									ocation (Stre ity or Town,		umber or Rur	al Route Nur	nber,	
To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific		29a. Certifier 1 ★ Certifying P (Check only one) 2 ★ Medical Exa	hysician: To the best miner: On the basis o and manner st	ot examina	owledge, death ation and/or inv	occurred	at the time	e, date and pla inion, death oc	ce, and du curred at t	ie to the cau he time, dat	ise(s) and e and pla	d manner as s ce, and due t	stated. o the cause(	(s)	
Withir Comp		29b. Signature and title of certifier				29	c. License					gned (Month,			
/		1/1/11/2		in			1285	-000		A	PRIL	3,200	06		
ũ		30. Name and address of person who MATTHEN PIPECIA	or, MD	6w	NORTH	WOH	er st	REET	BALT			LVLAND		7	
State Registrar		31. Date filed <i>(Month, Day, Year)</i> APR <b>0 3 200</b> 6	32. Registi	rar's Signa	ature	0									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 3. Time of Death **Physician** John Pepe /Medical 4a. Facility Name (If not institution, give street and number)
FY ANKIIN SQUAYE HOSDIT Examiner 5. Social Security Number **Funeral**  Birthplace (State or Foreign Country) Days 1**⊠**M 2□F Hours Months 89 092-05-9700 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits other traumatic event, the Mudical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 X No Baltimore Essex 10e, Street and Number 10f. Zip Code 10g. Cilizen of What Country? or items 23a 1108 Oak Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 40-44 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, While, etc. 1 Never Married 2K Married 1 ☐ Yes 2 1 No Specify: Specify: white 3 Widowed 4 Divorced "netural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is 1 and 2 should be filed within if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pepe Ralph Rose Rubano 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 sl ment of Heelth an ant: If item 27 is r Elva D. Pepe - wife 1108 Oak Avenue, Essex, MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or Chesapeake Crematory 3/31/2006 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signature of Funeral Service Ligensee CAFA, Stephen D. Lohrmann, 8717 Green Pastures Drive, PA Towson, MD M00986 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a gunsequence of) The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? s certificete has b lirector, page 2 s 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death | Check only one 37 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred To the now, within 24 hours efter death.
To the Funeral Director: Aft 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed, (Month, Day, Year) Name and address of person who completed cau who completed cause of death (Item 23a) (Type, Print) Dakwood no Stelos 2106,1

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Reputrar's Signature

_			1 - For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of I rtificate of		d Mental Hy	giene (	06 10171
	Physic	ian	Decedent's Name (First, Middle, I	ast)				2. Date of De	eath Day	3. Time of Death
	/Medi	cal	Paul	L.	Portri			March	30, 200	06 10:10 A <sup>M</sup>
1	Exami	ner	4a. Facility Name (If not institution, g			4b. City, Town, o	or Location of De	eath	4c. County	
	Funeral		Baltimore Wash: 5. Social Security Number 6.	ington Medic	cal Center (In yrs. last birthday)	GLen Bui	mie   If Under 24 F	Irs. 8. Date of Bir		Arunde1  9. Birthplace (State or Foreign
Н	Director		002-14-8786	4 TX - T -	83 Yrs.	Months Days			1, Year) 1922	Maine
	D .		Usual Residence of Decedent  10a, State 10b, County						,	
	laryla shov	5	,		10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
	the N	ect	Md. Anne A	Arundel		Pasadena	l			
	3a or	D	2048 B Kurtz /	Ave.		10f. Zip Code 211	22		10g. Citizen of US	
	death me 2	nera	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13. V			(Specify Yes or No lerto Rican, etc.)		ce - American Indian,
21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Itsm 27 Is marked other than "natural", or Itsms 23e or 28e-f show other traumatic event, the Mudical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 3 Xidowed 4 Divorced	1 XYes 2 No If Yes, Give Year or Dates:	)	fYes, specify Cub I□Yes 21X No	an, Mexican, Pu Specify:	erto Rican, etc.)	Specif	ck, White, etc.
2-0	72 hc	Completed	15. Decedent's (Specify only highest g	Education	16a. Deced	lent's Usual Occup	ation	wating	16b. Kind of B	usiness/Industry
121	hen hen	d H	Elementary/Secondary (0-12)	College (1-4or 5+)	)	kind of work done		working .	0 /	D - 1 1 1 1 1
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Mai	d 2 sh th and 7 le n traun		19a. Informant's Name/Relationship					Rural Route Numb		
ē,	1 end 2 Heelth Ism 27 other tra		Linda Loring 20a. Method of Disposition	Daughter	2048 20b. Place of Dispos	B KUTTZ	Ave. Pa	sadena, M		2 City or Town, State
ē			1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Citionio vai nom otato	20b. Place of Dispos					
Baltimore,	orts orts	1	21. Signature of Funeral Se vice in		Metro Cre	Name and Addre		10/06 tallings	Funeral	re, Maryland
m	Depa Impo		hu d	* 1	31	I11 Mount	ain Rd.	Pasadena	a. Md. 2	1122
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or corshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	consequence of): 5clevotic	t Three	mhose	s Pan Dis	sease	Approximate Interval Between Onset and Death
D. Box 68760,	ne death certificate be executed the attending physicien and hed for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	Due to (or as a of a control of	pregnancy □Fetal death 3□	Ectopic pregnancy Other (specify)			23d. Dat Mo	te of delivery nth Day Year
P.O.	hat the d by setac		Part II. Other significant conditions	contributing to death but a	not resulting in the un	derhina cauca and	on in Part I	220 Did to	obassa usa sast	ribute to the cause of death?
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of Vital Record	The tay ate has page 2	ompieted by							rmed?	Were autopsy findings available prior to completion of cause of leath?
<u>a</u>	icien: Th certificate rector, pag	Bec	25. Was case referred to medical				26. Place of D	eath   Check only o		Yes 2 No
× ×	Q: 00 X	To	examiner? 1√DYes 2□ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatient	3□ DOA Oth		Home 5 ☐ Resid		er (Specify)
Ĕ	ing P		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injun Work	at	28d. Describe h	now injury occurr	ed
<u>s</u>	Attending ir death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not it	TO DE L		0000	res 2 7 No		patie	or fluing
=	after Dirsc	ertif	4 Homicide determined	building, etc. (				28f. Location (S City or Tow	Street and Number (Number 1975) State	er or Rural Route Number.
_	Hospital     24 hours a     Funeral letely filled		29a. Certifier 1 ☐ Certifying P	hysician: To the best of n	NSING ho		up, date and play	omile.	MILIA	IL CO. MI
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only Medical Exa	miner: On the basis of ex and manner stated	tamination and/or inve	estigation, in my or	pinion, death oc	curred at the time.	date and place, a	and due to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier			29c. License	number		29d. Date signed	i (Month, Day, Year)
			· Cerrol Ha	llain in	rd	OCME		M	iarch 31	. 2006
1	16		30. Name and address of person who	completed cause of deat	0	rint)				
-			31 Data filed (Month Day Vacat	IU NUM		111 Penn	Street	, Baltimo	re, Mary	yland 21201
	Sta	te	31. Date filed (Month, Day, Year)	2000 32. Soistrar's	Signature	2.16				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19b per fh 9854 4-3-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year Francis Rolls, Jr 1:40 PM Koland 03 2006 /Medical 4a. Facility Name (If not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore NIA 1027 (athedral Street Apt. # F-9 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 11. 8. 1939 Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F Months 218.36.5887 Director ldo Yrs. Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28a-f shov other treumatic event, the Modical Examinal must be notified at MD NIA Director Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1027 Cathedral Street Apt. #F-9 USA 21201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: þ 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Services 12th grade Counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roland Roles, Sr. Ilan Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Attack (Coerany Number or Rural Route Number, City or Town, State, Zip Code) Patricia Serugos 2241 Mc Elder Greet Baltimore MD 21205 Dister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ö permit. Page Department of Importent: If any injury or once. GreenMount 04.07.06 Baltimore MD ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 12. Name and address of Facility Funeral Services 49105 YOYK Koad Bartimore, MD 21212 Eur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAKDIAC ARRHYTHMIA Physician disease or condition resulting in death) 48 hu /Medical Due to (or as a consequence of): Examiner STAGE RENAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VASCULAR 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 🙀 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the attending physician and hed for use as the burial transit Box 68760 signed by the a P.0. Division of Vital Records, certificate has Hospital or Attending Physicien: this funeral After after death. To the Hospital or Att within 24 hours after d To the Funeral Direct filled in by

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death

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ont: If item 27 is marked other then "neturel", or ite

If item 27

Baltimore, Maryland 21215-0036

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Medical

29c. License number

152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

10035706

SATIMONE, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G-HANDOUR

5601 LOCH RAVENBLUD

32. Registrar's Signature

APR 0 3 2006

UΙ	OK KICH	AK	1_ For State		epartment of Health and I Certificate of Death		4 U U D
	Physici		Registrar  1. Decedent's Name (First, Middle C		ocranicate of Death	2. Date of Death MonthDa	3. Time of Death
21.0	/Media	al	4a. Facility Name (If not institution, gi	) i Chards	4h City Tours or Location of Double	MARCH 30	0, 2006 1608 P M
1	Examir	er	JOHNS HOPKINS HO	OSPITAL	4b. City, Town, or Location of Death BALTIMORE CITY	1	N A
	Funeral Director			Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day, Year	9. Birthplace (State or Foreign Country)  Maryland
	aryland show	_	10a. State 10b. County	10c. City, Town			10d. Inside City Limits
	r 28a-f	<b>Funeral Director</b>	10e. Street and Number	Tap	10f. Zip Code	10g. C	1 ☐ Yes 2★No
	eth with	rai D	7809 BICMI	ngham Ave	21234		USA
900	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified alonge.	by	11. Marital Status  Never Married 2 Married  3 Widowed 4 Divorced	12 Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert</li> <li>Yes 2 No Specify:</li> </ol>	pecify Yes or No- p Rican, etc.)	14. Race · American Indian, Black, White, etc.  Specify: Black
21215-0036	in 72 ho n "natu fedical	Completed	15. Oecedent's E (Specify only highest gi	ade completed) ((	ecedent's Usual Occupation Give kind of work done during most of wor ifg. DO NOT use retired)	king 16b. h	Kind of Business/Industry
212	ed with ygiene.	Comp	Elementary/Gecondary (0-12)	College (1-4or 5+)	Laborer	1	ndustrial
Maryland	id be fil ental H ked ott	To Be	17. Father's Name (First, Middle, Las	chards	18. Mother's Nan	ne (First, Middle, Maide)	n Sumame)
<b>lary</b>	2 should and Men is marke	-	19a. Informant's Name/Relationship		Mailing Address (Street and Number or Ru	ral Route Number, City	
	tem 27		20a. Method of Disposition	Cley (Mother) 18	109 Birmingham	Ave, tark	ocation - City or Town, State
Baltimore,	Pages ment of I ant: If its ury or o		Burial 2 Cremation 3 Donation 5 Other (Special Control of Control	Removal from State	crematory or other place)	5/06 Bc	Utinore, MD
Balt	permit. Departrimportu		21. Signature of Funeral Service Lice	nsee Lin	Varea Address Craw of a	we Fun	eral Services
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	aplications that caused the death. Do not	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Multiple	Gurshot Wound	5	Onset and Death
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P.O. Box 6	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
	that the ad by th detaché	Phys	9 Unknown	9□ Unknown contributing to death but not resulting in the	as underlying cause gives in Part I	23e Did tohacco	use contribute to the cause of death?
Division of Vital Records,	quires t	ed by		Solution and the control of the cont	a dideliying cause given in Fatti.		No 3 Probably 4 Unknown
eco	# W a.	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E E	hysician: The la his certificate ha: I director, page 2		25. Was case referred to medical			performed?	deciri?
<u> </u>	hysicia his cert I direct	To Be	examiner? 1 XYes 2 No	Hospital: 1 ☐ Inpatient 2 ER/Outpa	O#	th Check only one ome 5 Residence	6 ☐Other (Specify)
0 0	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  3/30/06	Work?	28d. Describe how inju	•
N N	i or Attending P after death. Director: After t I in by the funera	Certification;	3 Suicide 6 Could not t 4 Homicide determined	e 290 Place of Injury. At home form	2 1	28f Location (Sweet a)	nd Number or Bural Boute Number
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medicai	(Check only 2 X Medical Example)	niner. On the basis of examination and/o and manner stated.	or investigation, in my opinion, death occur	red at the time, date an	d place, and due to the cause(s)
)	To To	2	29b. Signature and title of certifier	Hallan mg	29c. License number O.C.M.E	29d. Da M.	ate signed <i>(Month, Day, Year)</i> ARCH 31, 2005
			30. Name and address of person who	completed cause of death (Item 23a) (Ty			21201
	Sta	e	31. Date filed (Month, Day, Year)	7,07.0.	INN STREET BALTIMORE	E, MARYGAMD	Z1201
	Registr	ar	APR 0 3	L.	Sparks .		
DH	MH 17 Rev 1/20	01					

	1	For State Registrar	State of Ma		epartment of F Certificate of			leg. No.	006	10171
*		Decedent's Name (First, Middle, La	ast)				2. Date of Dea Month	Day	Year	3. Time of Death
hysicia /Medic	al	William		Rodwell			03	25	2006	/
xamin	_	4a. Facility Name (If not institution, gi		SPITA	4b. City, Town, o	r Location of Death	_	4c. C	ounty of Deatl	h
	Ġ.	1000		(In yrs. last birti			8. Date of Birtl (Month, Da)	n	9. Birtl	hplace (State or Foreign
neral   ector			11X M 2□ F		rs. Months Days	Hours Min.	(Month, Da)	, Year) -41	Co	Va.
	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits
event, it's Medical Examiner must be notified at	ö		AT 70							Y☐Yes 2☐No
	Funeral Director	Md.  10e. Street and Number	NA	Ba.	ltimore 10f. Zip Code			10g. Citize	en of What Co	ountry?
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8	1 1	21. Signature of Fundral Service City			22. Name and Addre	ess of Facility	Ralt	T MOR		
a		Lu o o	1000	دره	22. Name and Addr	ess of Facility F.H. East			North	
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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

APR 0 3 2006

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		•	1- State RegistrAmend Item #5	Per FH G854	4/0 <b>\$</b> 8	rtifig <del>a</del> te	e of L	Death		Reg. 1	000	)	01/6
	Dharini		1. Decedent's Name (First, Middle, Last)			0 011			2. 🗆	ate of Death	Day \	Year	3. Time of Death
	Physici /Medio		ELIZABETH STRAINI	NG RATHELL					Ma	rch 30,	2006	041	9:52 A M
	Examin	er	4a. Facility Name (If not institution, give			,		Location of	of Death		lc. County of		
			Good Samaritan Ho 5-Social Security Number 6. Security Number		last hirthday)	Ba1	timo	re If Under	24 Hrs.   o n	ate of Birth		N/A	ace (State or Foreign
В	Funeral Director			M XX 88	Yrs.	Months	Days	Hours		19,191	7	Mary	land
	D		Usual Residence of Decedent						1				
	anylan	_	10a. State 10b. County		y, Town or Lo							10	od. Inside City Limits  YXYes 2 □ No
	the M	ecto	Maryland N/A	Ba	ltimor	e 10f. Zip	Code			100	Citizen of Wh	nat Cours	
	3a or	ā	1100 E Gittings Av	enue			1239			109.	USA	at Court	ay:
	72 hours after death with the Maryland Insturel', or items 23s or 28s-f show deal Examiner must be motified at	Funeral Director		12. Was Decedent Ever in U	.S. 13.	Was Deced	lent of Hi	spanic Ori	igin? (Specify n, Puerto Ricar	Yes or No-	14. Race -		
98	or its	y Fu	1 Never Married 2 Married	Armed Forces?√ 1 ☐ Yes 2 ♠No If Yes, Give		1 ☐ Yes X		Specify:		i, etc.)	Specify:	White, e	
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Maryland 21215-0036	ges 1 end 2 should be filed within 72 hours after death with the Marylan it of Heelth and Mental Hygiene. If Item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic avant, the Madical Examiner must be notified at		19a. Informant's Name/Relationship (Ty.) Anne-Marie Blauste							ute Number, Cit e Hall			
	1 end Heelth am 27 ther tr	ļ	20a. Method of Disposition		Place of Dispo		-	- Not	Date		Location - C		
Baltimore,	eges int of t: If it y or o		1 ☐ Burial 2 XX remation 3 ☐ R	emoval from State	emetery, crer enMoun	natory`or o	ther place		4/1/06				Maryland
Ħ	permit. Peg Department Important: I any injury o		Donation 5 ☐ Other (Specify)  21/Signature of Funeral Service License					•		ell-Wiede			•
ä	Depa impo any ir		Konnis Steska	Kenakei	)					oad Baltin			
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	chions that caused the death	h. Do not ent	er the mode	e of dying	, such as	cardiac or res	piratory arrest,		5.5.45	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Hyperkusiv	Ata	liose	levo	tic (	Partio	vascul	antis		Onset and Death
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Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pro					23d. Date Month		ry Day Year
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<u>α</u>	res that the igned by be detacted	by Ph	Part II. Other significant conditions cor	tributing to death but not res	ulting in the u	nderlying ca	ause give	n in Part I.	. :	23e. Did tobacc	use contrib	ute to the	e cause of death?
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of\	Physician: this certifical ral director,	ဥ	TEXTES 2 No	1	ER/Outpatier			4 🗆 140		5 Residence			)
	ing After une	tlon:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 2	8c. Injury Work	at ? ∕es 2 ∐ !		Describe how in	lury occurred	1	
Division	i or Attanding after death. Director: Afte i in by the fune	flca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, str					ocation (Street	and Number	or Rural	Route Number,
Ö	호류등	Certification:	4  Homicide determined	building, etc. (Specif		,				City or Town, Sta			
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		292 Certifier 1 Certifying Physical Examin	ricinn: To the best of my kno	wledge, death	occurred (	at the tim	e, date an	id place, and d	ua to tha cause	(e) and mann	lar as sta	rtad.
	To the H within 24 To the Fi complete	ledical	one)	ner: On the basis of examina and manner stated.	mon and/or in				ith occurred at				
	To To	Σ	29b. Signature and title of certifier	1000	,		. License	number			ate signed (		
	, 1	1	- Caral p	fellavu			CME			Mar	ch 31	, 200	06
	10		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,		Penn	Stre	et. Bal	Ltimore,	Marvi	land	21201
4	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture A	asks)		02.0					
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death **Physician** Year milh MONI aniel /Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 12-28-0446 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Medical Examinar must be notified at Yes 2□ No Director MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) orrections Name (First, Middle, Last) Mother's Name (First, Middle 18 Be rmant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If ite any Injury or ot Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HEARS Vetastatic lorecta disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 Who 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has al director, page 2 autopsy performed? 2 No 1 Yes 2 No 1 Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \to \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) 9 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

APR 0 2006

Suct-

North Broadway

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

to

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

sistrar's Signature

Himore

29c. License number D6287

MD

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:20am м Helen Louise Stewart **Physician** March 23,2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Hunt Valley Maryland Masonic Home If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🖫 F 428-10-7285 90 Yrs 11/7/15 MS Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Baltimore Cockeysville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 300 International Drive 21030 USA death Funerai 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items Black, White, etc. ☐Yes 2 No 1 Yes, Give filed within 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2√2 No Specify: Specify: Baltimore, Maryland 21215-0036 X₩idowed 4 Divorced Completed by Year or Dates: "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 9 0 othar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avent 9008. Be Lillie Taylor Carl Spooner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Freeland MD 21053 Patricia Biggs / Daughter Walker Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Premoval from State 4 Donation 5 Other (Specify) BiloxiNational Cemetery 3/28/06 Biloxi, ` 4 □Donation 22. Name and Address of Facility 21. Signature o Fur eral Service Licensee Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Melaslatii allemo Carcuma Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 Yes 2 No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 No 1 Yes certificate Division of Vital o the Hospital or Attanding Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA ို 1 Yes 2 No this 28c. Injury at Work? After thi funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ★★ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3-23-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto, and 212 350 ROBENT LIBE 31. Date filed (Month, Day, Year) State APR 0 3 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** SCHNEPF 8:51 PM 2006 FRANCES MARCH 24 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL (ENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□M 2QF Yrs. April 29,1951 Director 213-58-0943 54 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Tyes 2 □ No Director Baltimore City Maryland N/A 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? filed within 72 hours after deeth with or items 23a or 5006 Delagrange Avenue 21205 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify. Specify. à 3 Widowed 4 Divorced White "neturel" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Own Home Homemaker permit. Peges 1 and 2 should be file. Department of Heelth and Mental Hyg Important: If Item 27 is marked other any Injury or other traumetic. traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Jane Hunt Donald Richard Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5006 Delagrange Ave. Baltimore, Maryland 21205 Mr. William J. Schnepf (Husband) Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 15 □ Other (Specify) Sacred Ht. of Jesus Cem 3/29/2006 Dundalk, Maryland 21. Sign yure of Juneral Shy ice Licens 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 5 DAYS EAILURE RESPIRATORY /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events PULMONARY Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, Completed by Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 4☐Pregnant at time of death 5 Other (specify) page 2 should be deteched Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes of Vital Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of confider 29c. License number 29d. Date signed (Month, Day, Year) MARCH 30, 2006 RES 000 JACOB 30. Name and address of person the completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVE. , BALTIMORE, MD 21224 DR. SNEHA JACOB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygienen 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Winifred Muriel Showalter Month Day March 28, 2006 2:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Care Ctr. Dundalk Baltimore Co. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 22,1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 383-20-3811 82 Director Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23s or 28s-f show the Medical Extratifier name be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2806 Bay Drive 21219 United States filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2% No Specify by 3 Widowed 4 ☐ Divorced White Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Waitress Catering Co. 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth any lighty or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Kerr Henrietta Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Moore (Daughter) 2806 Bay Drive Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 3/31/2006 Middle River, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LONGESTIVE HEART Physician /Medical Examiner DIA BETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the hours transfer. PERTEKSION Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 ☐ Yes 2 No 2 No Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 10 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lace Dien dall 2 Mark of Date filed (Month, Day, Year) -32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Day 3 Decedent's Name (First, Middle, Last) Month Year **Physician** 200 IARCM JUINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BUILTIMORE Q If Under 1 Year If Under 24 Hrs. Hopkins H058H01 N/A ne Johns Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 Ø F Hours Months Days Yrs. 215-22-1001 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show il Hygiene. other than "natural", or iteme 23a or 28a-f ehov vent, the Micilical Examiner must be notitied at 1 Tyes 2 No Md. Anne Arundel Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 202nd. St. 21122 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (1) No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-Il Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0036 Specify: Specify: <u>چ</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Steel Industry or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event RDGs. 17. Father's Name (First, Middle, Last) Earl Serena Irene Stickline ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 715 202nd. St. Pasadena, Md. Robert A. Cosner Sr. (Husband) 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 4/1/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home PA 3111 Mountain Rd. Pasadena, Md. 21122 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and neach line. Approximate Interval Between Onset and Death 23a. Part1. Enter the dease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) SUPSIS 301745 Physician /Medical Due to (or as a consequence of): arian cancer, stage 30 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) the t 9 Unknown signed by the 23a. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2XNo 3 Probably 4 Unknown should should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗌 No 1 ☐ Yes 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 FR/Outpatient 3□ DOA After thi funeral 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 10 Contifying Physician: To the best of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in my opinion, death accounted to the cause(s) and manner as stated within 24 hours a To the Funerel I 29a. Certifier cai Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thWolfe Jones 600 NoB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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**ORIGINAL** 

		•	For State Registrar	State of Maryland		rtment of H		d Mental	Hygiene Reg. No.	006	10182
	Dhomini		1. Decedent's Name (First, Middle, Last)						of Death h Day	Year	3. Time of Death
	Physicia /Medic	al	Hazel Catheri						h 30,		10:20 AM
1	Examin	er	4a. Facility Name (If not institution, give str 216 5th Street	reet and number)		4b. City, Town, or Lothi		eath		County of Dea ne Arun	
			5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date	of Righ	9. Bir	thplace (State or Foreign
	Funeral Director			M 3√XF 85	Yrs.	Months Days	Hours I	Min. Jan	17, 19	C	shington DC
			Usual Residence of Decedent								
	how	_	10a. State 10b. County		, Town or Lo						10d. Inside City Limits
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:	with the port	Funeral Directo	10e. Street and Number 216 5th Street			10f. Zip Code 2071	1			ted Sta	
	ne 23	era		2. Was Decedent Ever in U.S	S. 13. 1	Vas Decedent of Hi	spanic Origin	? (Specify Yes	or No-	14. Race - Am	
	r Itan	臣	1 □ Never Married XX Married	Armed Forces? 1 ☐ Yes 2 💥 No	1	f Yes, specify Cuba	n, Mexican, P	uerto Rican, et	c.)	Black, Whi	te, etc.
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CA :	Her Illed		17. Father's Name (First, Middle, Last)		поше	maker	18. Mother's	Name (First, A		n Home Sumame)	
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ary.	2 should be f and Mental f is marked or raumatic eve	-	19a. Informant's Name/Relationship (Type			ng Address (Street a				r Town, State,	Zip Code)
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Baltimore, Maryland	of He of He if Item		20a. Method of Disposition 1. ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	lace of Dispo emetery, crei	sition (Name of matory or other plac	) April	. 3, 200	20c. Lo	cation - City or	Town, State
Ĕ	Pag ment ant: I		4 □Donation 5 □ Other (Specify)	Re	surrec	tion Cem	etery		Cli	nton, M	aryland
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	40360		23a Part 1. Enter the disease, or complici	y moo257		Alexandri				on, MD	20735 Approximate
			shock, or heart failure. List only one	cause on each line.			g,		,		Interval Between Onset and Death
/	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ	ance of):	*					18
	Examiner				,						
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œ.	it the death certific by the attending p tached for use as	Physician/M	in the past 12 months? 1  Yes 2 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregnancy Other (specify)			-	Month	Day Year
P.O.	at the 1 by th etach	Phys	9 Unknown		41 - 1 - 41 -			220	Did tobases (	oo oostebuto l	o the cause of death?
S,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	ρ	Part II. Other significant conditions cont	Uppering to death per nor resi	and an use u	rideriying cadse givi	errir Farti.	200	1 ☐ Yes 2		robably 4 Denknown
Records,	v require been si should I	Completed						242	. Was an	24h Were a	utopsy findings available
Be	0 - 0	mp						_	autopsy performed2-	prior to death?	completion of cause of
_	ician: Th certificete ector, pag	a	25. Was case referred to medical				26 Place of	f Death (Check	Yes 2 No	1 1 10	s 2□No
<u> </u>	Physician: r this certific ral director.	To B	examiner?	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA Oth		ing Home 5		6 □Other (Sp.	ecify)
ام ر	ng Ph ter th neral		27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o				cribe how injur		
<u> </u>	Attending r death. sctor: Afte on the fune	catic	2 ☐ Accident investigation				Yes 2 □ No				
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office			or Town, State		Rural Route Number,
ш	To the Hospital or Attending Physician: within 24 hours eiter death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a, Certifier 1 Certifying Physi	ician: To the best of my kno	wledge, deat	h occurred at the tin	ne, date and	place, and due	to the cause(s	and manner a	as stated.
	Hotoly	Medical		er: On the basis of examina and manner stated.							
	To th Withir To th comp	Ž	29b. Signature and title of certifier	1 staf	f- crnist	29c. Licens		211		te signed (Mor	oth, Day, Year)
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	6		30. Name and address of person who cor		23a) (Type			neter Rd	0.1	,	
	<i>y</i>		WADE FLETUHER, N 31. Date filed (Month, Day, Year)	32. Begistrar's Signa	ture	Andre	WS AFB	, MD 20	162		
	Regist	ate rar	APR n 3 2006			ask)					

DHMH 17 Rev 1/2001

			1 = For State Registrar	State of	Marylan	•	artment o				Reg. No.	6	10183
	Dhysiai		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic	_		rgaret Li		Troiar				March			10:04 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Tov	vn, or Locat	tion of Death		4c. County	of Death	
				ward's Lo			) If Under 1 Y		apolis				rundel
	Funeral			5. Sex 7 1 ☐ M 21X ☐ F	7. Age (In yrs.	last birthday Yrs.		ays Hou		8. Date of Birt (Month, Da	n y, <i>Year)</i>	Cou	place (State or Foreign intry)
	Director	}	577-26-0393 Usuel Residence of Decedent		86					January	1, 1920	L	<u> Delaware</u>
	land		10a. State 10b. County		10c. Cit	y, Town or L	ocation						10d. Inside City Limits
	Mary	ō	Maryland Mon	tgomery			(	hevv	Chase				1 ☐ Yes 2X No
	28a	Directo	10e. Street and Number	egomery	1		10f. Zip Co		onabe		10g. Citizen of	What Cou	intry?
	3a or		6100 Wa	stern Ave	n110			208	R15		IIn:	ited	States
	me 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent			ecify Yes or No- Rican, etc.)		ce - Ameri	ican Indian,
٥	after or life	F	1 ☐ Never Married 2 ☐ Marrie	Armed For	2 X No		1 ☐ Yes 2 🕅			Hican, etc.)		ck, White	, etc.
3	el', c	þ	3  Widowed 4 □ Divorced	If Yes, Give Year or Da	e ites:		Tes 2M	No Spe	спу:		Specif		White
21215-0036	filed within 72 hours after death with the Maryland Hygione. ther then "natural", or items 23s or 28s-f show ent, the Medical Examinat must be notified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deci	edent's Usual O	ccupation one during	most of work	ing	16b. Kind of B	lusiness/lr	ndustry
7	Me n	ğ	Elementary/Secondary (0-12)	Coffege (1-	-4or 5+)	life.	e kind of work a DO NOT use r						
7	filed w Hygier ther th	S		4			Home	emakeı		(F) + 147 ( #		Own H	Iome
2		Be	17. Father's Name (First, Middle, La					18. N	iotners Name	e (First, Middle,			
<u>\frac{2}{a}</u>	2 should be and Mental is marked o	ဥ		uBose Phi	illips,						illian		
-	2 sh and iem	n d	19a. Informant's Name/Relationshi Marguerite							al Route Numbe			
	jes 1 and 2 should t of Health and Men if item 27 ie marke or other traumatic		Trolano Feldma 20a. Method of Disposition	nn/ Daugh			009 Howa			Annapol:	is, Mary		
altimore,	Pages 1 nent of F int: if ite iry or of		1 N Burial 2 ☐ Cremation 3		State	emetery, cre	ematory or othe	r place)	Ma	rch 2006		,	
	Pa tmen tant:		4 Donation 5 Other (Spe		For		coln Cer				Brenty	wood,	Maryland
Ba	permit. Pages Department of Important: if it eny injury or o		21. Signature of Fuheral Service LI	X	/ M00	335 B	ethesda- ethesda- ethesda	-Chevy Mary	Chase	20814-35	7557 W	iscor	neral Home/ nsin Avenue
			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that can't one cause on ea	aused the deat	h. Do not er	nter the mode o	dying, suc	h as cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	.,		Tinko	corel	ral	hor	orcho	40		Onset and Death
п	/Medical		resulting in death)	Due to (	or as a consec						1		- Luc
	Examiner		Convention to the tipe and tipe	ь									
7	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a consec	uence of):							
V	cuted	Examiner	that initiated events	c									
o	e exe		resulting in death) Last	Due to (d	or as a consec	uence of):							
58760,	cate be executed physician and the burial-transit	edicai		d									
		Med	fF FEMALE:										
Box	The law requires that the death certification has been signed by the attending plage 2 should be detached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Feta	if death 3	□Ectopic pregr					ate of deliv onth	very Day Year
<u>.</u>	the a	Sic	1 ☐ Yes 2 █ No 9 ☐ Unknown	4□Pregna 9□Unkno	ant at time of o	leath 5	Other (special	ý)					,
P. O.	res that the de signed by the a be detached t	F.	Part II. Other significant condition	e contributing to de	ath but not rec	ulting in the	underhing eque	a awan in E	Part I	23e Did to	nhacco use con	tribute to	the cause of death?
ŝ	res th signe I be d	þ	Part II. Other significant condition	is contributing to de	atti but not ias	uning as the	underlying caus	e given in r	aiti.	1 🗆 1			bably 4 Dunknown
0	w require been si should t	Completed					·				-/-		
ec	e law has b	npidu								24a. Was		Were aut prior to death?	opsy findings available ompletion of cause of
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Ĭ,	Physician: r this certifica ral director, i	Be	25. Was case referred to medical examiner?	Hospital:				1 0.4		h Check only o			Daughters
5	Phys this al dir	To	1 Yes 2 No 27. Manner of Death	28a. Date o		ER/Outpation 28b. Time			Nursing Ho	ome 5 Resident			m) Home ters
Ë.	ing A	o	1 Natural 5 ☐ Pending	(Monti	h, Day Year)	fniury	M 280.	Injury at Work? 1 ☐ Yes	2 🗆 No	200. Describe i	iow injury occu	1160	
Sic	Attending ir death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	ot be 380 Bfroo	of Injune. At h	omo form o	treet, factory, o		2 0140	28f Location /	Street and Num	har or Ru	ral Route Number,
Division of Vital Records,	al or Attend after death Director: ,	Certification:	4 Homicide determin	led 200. Flace buildin	ng, etc. (Speci	(y)	певі, іаскогу, о	ilice		City or Tov		001 01 7101	ai riodio Number,
_	pital ours a eral l		29a. Certifier 1X Certifying	Physician: To the	hest of my kni	wledge des	th occurred at t	he time da	te and place	and due to the	cause/s) and m	anner as	stated
	Hos 24 hc Fun stely	Medical		xaminer: On the ba	asis of examina								
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and tive of certifier				29c. L	cense num			29d. Date signe	ed (Month	, Day, Year)
	- s - ō		> 7 MA	aus				US)	036		37	1. 0	0 2006
	. 1		30. Name and address of person w	no completed cause	e of death (Ite	n 23a) (Tvo	Print)	18			Mar	cn 2	8, 2006
	10		Gary Sprouse, M					ester	Mary	1and 21	619		
	Sta	te	31. Date filed (Month, Day, Year)	32/A	egistrar's Sign	ature	e ve on		, LIGITY	zana zi			
	Regist		APR 0 3	2006	egistrar's Sign								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month ARCH Pay 29, 2006 4:42P M Vitaglione Philomena Helen 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number)
Saint Joseph Medical Baltimore Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, April 8 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1□ M 2\ F 81 076-18-3810 Yrs. 1924 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Westminster 1 ☐ Yes 2 No Md Carroll 10f. Zip Code 21157 10e. Street and Number 10g. Citizen of What Country? USA 1300 Campus Court 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) law clerk legal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Maria Nicoletta DeNapoli Pietro Legrottaglie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 616 Blankner Rd., Sykesville, Md 21784 Louis Nardi (son-in-law) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition tX Burial 2 ☐ Cremation 3 ☐ Removal from State Springfield Cemetery 4-1-06 Sykesville, Md 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHaight Funeral Home & Chapel 21. Signature of Funeral Service License C thought your P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AORTIC STENOSIS 23d. Date of delivery topic pregnancy Month Day Year ther (specify) 23e. Did tobacco use contribute to the cause of death? rlying cause given in Part I. 1 Tes 2/3NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes No 24a. Was an autopsy performe 1 Yes 3□ DQA 28c. In

Ex to the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Physician /Medical

Examiner

**Funeral** 

Director

or 28a-f show

Director

Completed by Funeral

Be

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"natural", or iteme 23a or 28a-f ehov edical Exeminer must be notified at

Pages 1 and 2 should be filed within 72 hours after nant of Health and Mental Hygiene.
ant: if item 27 te marked other then "natural", or itel ury or other traumatic event, the Medical Executor

permit. Pages 1 Department of H Important: if ite eny injury or ot once.

**Physician** 

Baltimore, Maryland 21215-0036

death with the Maryland

lical iner		resulting in death)	Du	ue to (or as a conse	quence of):
÷	lner	Sequentially list conditions, if any, Jacob 9 to immediate cause. Enter Underlying	b	e to (or as a conse	mence of):
e burial-trans	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ue to (or as a conse	quence of):
should be detached for use es the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 21☐ No 9 ☐ Unknown	1 🗀 4 🗆	os, outcome of pregn Live birth 2 ☐ Fet Pregnant at time of Unknown	aldeath 3⊡Ed
completely filled in by the funeral director, page 2 should be detached for use es the burial-tra	Completed by Pt	Part II. Other significant conditions of ACUTE RENAL FAII	ontributing LURE	g to death but not re	sulting in the unde
director, p	To Be C	25. Was case referred to medical examiner?	Hospital:	1 Inpatient 2	] ER/Outpatient
completely filled in by the funeral director, page 2		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		ate of Injury (Month, Day Year)	28b. Time of Injury
d in by th	ertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e.	Place of Injury - At I building, etc. (Spec	nome, farm, stree ify)
letely fille	Medical Certification;		niner: On	To the best of my kn the basis of examin d manner stated.	
сошо	Me	29b. Signature and title of certifier		0 1	. 7

		26.	Place of Dea	ath (Cr	neck only one)	
3 🗆 🗅	Oth Oth	er: 4	□ Nursing H	lome	5 Residence	6 ☐Other (Specify)
М	28c. Injui Wo	y at	2 □No		Describe how inj	
, facto	ry, office			28f.	Location (Street a	and Number or Rural Route Number

9	City or Town, State)	
time, date and place	e, and due to the cause(s) and manner as stated.	

ne cause(s) and manner as stated.  e, date and place, and due to the cause(s
29d. Date signed (Month, Day, Year)
3 29 06

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE TOWSON. MARYLAND 21204 TIMOTHY LOW M.D. 7601

State Registrar

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 29 2006 12:10 pg Ethel Wyche /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2808 Norfolk Ave Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreig Scounty) S. Carolina 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 M 2 F Months Hours 212-80-3591 85 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a State "natural", or iteme 23a or 28a-f ehow edical Examiner must be notified at N/A Baltimore Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2808 Norfolk Ave 21215 Usa death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or item any injury or other traumatic event, the Medical Examples once. Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: Specify: Black þ 3 ₩idowed 4 Divorced ff Yes, Give Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma McManus John Blakney 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2808 Norfolk Ave Baltimore MD 21215 Earline Miller / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriaf 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Mem. Park Cem. 4/4/06 Randallstown MD. 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Ferral Service Mensee 5240 Reisterstown Rd Baltimore MD. 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Upper disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant

23c. If yes, outcome of pregnancy 4 Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

Month Dav

23e. Did tobacco use contribute to the cause of death?

neart Social

in the past 12 months?

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a Was an autopsy performed? 2 No 1 Yes

1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

25. Was case referred to medical

Hospital:

26. Place of Death (Check only one) Other: 4 Nursing Home Mesidence 6 Other (Specify)

28d. Describe how injury occurred

1 | Yes 2 | №6 27. Manner of Death 1 Natural

4 | Homicide

5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. injury at Work? 28b. Time of 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifiei (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

DOD 351074

29c. License number

29d. Date signed (Month, Day, Year)

WANGLOW Sminns Clemonsons 1909 & NUTLIEN PRINCIPS WITHOUT BUETMENT 31. Date filed (Month, Day, Year) 82. Registrar's Signature 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year) APR 0 3 2006



1 Inpatient 2 ER/Outpatient 3 DOA

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certificate

After this certification

Director:

within 24 hours after. To the Funeral Dire

filled in by

Hospital or Attending Physician:

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Be Completed

Certification: To

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:18PM Williams March 16 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Randalstown If Under 1 Year | If Under 24 Hrs. Valto. Northwest Hospital 8. Date of Birth (Month, Day, Year) April 28, 1917 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F 268-12-9835 Yrs 88 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location or 28a-f show other then "natural", or iteme 23a or 28a-f sho vent, the Medical Examinar must be notified at MD 1 ☐ Yes 2 No Baltimore Completed by Funeral Director Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10935 Liberty Road 21133 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3X Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cashier J.C. Penny Co. permit. Pages 1 end 2 should be filed v Department of Heelth and Mental Hygien Important: If Item 27 le marked other It eny injury or other treumatic event. Its once. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Milton Hart Alice Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marcia Thompson /Daughter 10935 Liberty Rd Randallstown MD 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🖼 emoval from State Tod Homestead Cemetery 3/22/06 Youngstown, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Ave. Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute pulmonary congestion disease or condition resulting in death) Due to (or as a consequence of): /Medical Examiner tailure Acute renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sete hes been signed by the ettending physicien and page 2 should be detached for use es the burial-transit volume contraction or Attending Physicien: The law requires that the death certificate be executed Intravascular Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Retroperitoneai Physician/Medical nemorrhad IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown HUDERTERSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Steeph Incocca I phomismonia autopsy performed/ 25. Was case referred to medical examiner? Osteoarthritis, Osteoporosis this certificete 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 16,2006 028462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Randallstown, Maryland 2113\$ North west Hospita

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 3 2006

32. Redistrar's Signature

			For State Registrar	State of M	aryland / [	Departmer Certificat			and M		giene	6	1018	37
2.1	Physicia	an .	Decedent's Name (First, Middle, Last)		MATIC					2. Date of Dea Month April	Day 20	Year 06	3. Time of 2:20	of Death
ı,	/Medic		FREDERICK  4a. Facility Name (If not institution, give str		WALLS		Town, or	Location of	of Death	VALTE	4c. Count		2.20	
	Examilia	er Sys	Frederick Memorial		al	Fre	ederi	.ck			Fred	erick		
920 0 -	Funeral Director		222-01-9388	7. Ag	e (In yrs. last bii 89	Yrs. If Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Aug. 1,	1916	9. Birth Cou Penn	place (State ontry) LSy1var	or Foreign nia
	buid be filed within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or itema 23a or 28a-f ehow atic event, the Mudical Examiner must be notified at		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside C	ity Limits
	Ba-f e	Funeral Director	Maryland Montgomer	:y	Clark	sburg					10g. Citizen of	Milhat Cau		<u>A</u> _140
	with the a or 2	Dire	10e. Street and Number	.d 11	Daal	107. 21	Code	7.1			U.S.A		intro :	
	ha 23	erai	12815 Prices Dist	. Was Decedent	Ever in U.S.	13. Was Dece	208 dent of Hi	ispanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)			ican Indian,	
ဖွ	or ite	/ Fur	1 Never Married 2 Marned	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give		1 Tes, spe		Specify:		nicall, etc.)	Speci	fv:		
21215-0036	hours ural',	d by	3 ₩idowed 4 □Divorced	Year or Dates:	160	. Decedent's Usu	al Occup	ation			16b. Kind of E	Wn:	ite	
7	in 72 n *nat	Completed	15. Decedent's Educa (Specify only highest grade	completed)		(Give kind of will life. DO NOT u	ork done o	durina mos	t of work	ing	Wallpa		•	
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D	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maiden Suma	me)		
Maryland	should Ind Mening Marke	ဥ	Frederick C. W		101	o. Mailing Addres	s /Street			West Number	er City or Town	State. Zi	in Code)n o	7.0
Ma	and 2 sho ealth and I n 27 is ma		Cheryl L. Beall -			2815 Pr								400
re,	s 1 and 3 of Health Item 27 other tr		20a. Method of Disposition	-	20b. Place o	of Disposition (Na ary, crematory or	me of			Date	20c. Location	- City or T	own, State	
Ë	Page ment c ent: If ury or		1 ⊠Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Denation 5 ☐ Other (Specify)		Bethe	1 Baptis					Columbu			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene properties if Item 27 is marked other than "natural", or itema 23a or 28a-f show important: if Item 27 is marked other than "natural", or itema any injury or other treumatic event, the Marchall Examiner must be notified at any increase.		21. Signature of Fun ral Service Licenses	ellian	N	26401	Ride	e Res	id. I	s P.A., Jamascus	, Mary	1 Hom	ne 20872	2
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	ine.	40 N i		g, such as	cardiac	or respiratory ar	rrest,		Approxima Interval Be Onset and	etween I Death
68760,	ificate be executed g physicien and as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as	s a consequence	of):								
P.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/M	IF FEMALE: 23 Lin the past 12 months? Li		e of pregnancy 2  Fetal death at time of death	h 3 Ectopic   5 Other (s		, 				ate of deli- fonth	very Day	Year
	The law requires that the ate has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions cont	nbuting to death		in the underlying		i SE			obacco use co Yes 2 ☐ No			
Reco	has bee	Completed		ENAL		LURE		D F			psy ormed?	prior to death?	topsy findings completion of	s available cause of
la		ပိ	CONGESTIVE	HE	ART	FAI	LUI		e of Deat	1 ☐ Yes	2 No	1 🗆 Yes	2 No	-
Ž	o p	0 8	examiner?	ospital:	ient 2 ER/O	utpatient 3 🗆 🖸	OA Oth			ome 5□Resi		ther (Spec	city)	
o uo	ding Phi h. After thi funeral	tion: T	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Inj (Month, D	ury 28b. ay Year)	Time of Injury	28c. Injur Wor	yat rk? Yes 2 ⊑	]No	28d. Describe	how injury occi	urred		
Division of Vital Records,	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir building, e	njury - At home, t	farm, street, facto	ry, office			28f. Location ( City or To	Street and Nur wn, State)	mber or Ru	iral Route Nu	mber,
	Hospitel 24 hours 2 Funeral I	edical C	29a. Certifier (Check only one) Certifying Phys		of examination a									(s)
	To the within To the comple	Me	29b. Signature and title of certifier					e number			29d. Date sign			
)			Dum Flo	Hin			02	880	8		04	101	1106	
6	1		30. Name and address of person who con		death (Item 23a	(Type, Print) West 7t	04-	coct	Free	derick	Marv1a	nd 2	21701	
)	9.000	260	Rusu Florin, N 31. Date filed (Month, Day, Year)		400 trar's Signature	west /t	ı Sti	eel,	LIC	uci i cito				
	St Regist	ate rar	APR 0 3 2006	All are	w K	Spark								

	•	For State Registrar		State of N		nd / Depa	artmen	t of H		and M	• •		000	10188
		Decedent's Name (First, Middle	e, Last)		-						2. Date of Dea	th		3. Time of Death
Physicia		Nellie G	1	Nater	102	A					Month	Day		1755 M
/Medic	_	4a. Facility Name (If not institution				<u>~</u>	4h City	Town or	Location of	of Death	April	40	2006 County of Death	1 , , = -
Examine	er	Johns Hopkins				7+r	40. 0,		timor		tv	1	1/A	
Consent		5. Social Security Number	6. Sex			last birthday)	If Under		If Under		8. Date of Birtl		<u> </u>	place (State or Foreign
Funeral Director		218-03-3796 Usual Residence of Decedent		м 2 <b>%</b> ] F	85	Yrs.	Months	Days	Hours	Min.	(Month, Da) Jan. 2	, Year)		place (State or Foreign htry) yland
ow ow		10a. State 10b. County			10c. Ci	ty, Town or Lo	cation						T	Od. Inside City Limits
Man	ğ	Maryland B	alti	more					Dund	alk				1 ☐ Yes 2⁄QNo
5-0036 72 hours efter deeth with the Maryland retural, or itema 23a or 28a-f show digal Examinat must be notified at	Director	10e. Street and Number 905 Wise Ave					10f. Zip	Code	2122	2			zen of What Cou ted Sta	-
na 23	Funeral			2. Was Decede	nt Ever in I	S 13 V	Nas Dece	dent of Hi	enanic Ori	gin? (Spe	cifu Vac or No		14. Race - Ameri	ean Indian
iten d	Š	11. Marital Status  1 ☐ Never Married 2 ☐ Mar		Armed Force	s?	.5.	f Yes, spec	cify Cuba	n, Mexican	gin? (Spe i, Puerto f	cify Yes or No- Rican, etc.)		Black, White,	
36 rs eff	ğ	3 XWidowed 4 □ Divorced	- 1	1 ☐ Yes & f If Yes, Give Year or Date:			1 🗆 Yeş	2 🔀 No	Specify:				Specify:	
9 of sign	ed ed	15. Deceden			J.	16a. Deced	ient's Heur	al Occups	ation			16h Ki	md of Business/In	nite
15 n 72 m	Completed	(Specify only highe		completed)		(Give	kind of wo	rk done d	during mosi	t of workir	ng	100. Kii	10 01 003111033/11	dustry
21215 1 within 7 jiene. rthan "n tre Madi	Ĕ	Elementary/Secondary (0-12)		College (1-4d	or 5+)	1	emake		,				Own Home	
be filed that Hyging other	ပိ	10 Years 17. Father's Name (First, Middle,	Last)			1101	Cinane		18. Mothe	r's Name	(First, Middle,			
- g & B &	To B	Herman Rede	nann						M	argaı	cet Law	son		
Maryla d 2 should th and Men 7 is marke traumatic		19a. Informant's Name/Relations	hip (Typ	e, Print)									Town, State, Zip	Code)
M alth alth 27 is		Mr. James H.	Wate	rfield	(Son)	8516	Map.	le Ro	oad :	Edger	mere, M	aryl	and 212	219
Baltimore, N permit. Pages 1 end Department of Health importent: If Item 27 any injury or other it		20a. Method of Disposition				Place of Dispo	sition (Nar	ne of	e)	D	ate	20c. Lo	cation - City or To	own, State
Page Page nt: If		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation — 5 ☐ Other (S		moval from Sta		celand				. 4/5	5/2006	Ва	ltimore	Maryland
alti	1	21. Signature of Funeral Service	-	e								5	dalk, Ir	
Department of the partment of		100000	$\leq$	2							dalk, M			
		23a. Part1. Enter the disease, or shock, or heart failure. List	complic	ations that caus	ed the dear	h. Do not ent	er the mod	le of dying	g, such as	cardiac o	r respiratory ari	est,	and 212	Approximate
Dhysisian		Immediate Cause (Final	only on			_								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	_ a.		as a consec	Can	cer				<u> </u>			
Examiner				046 (0)	as a consec	juerice or,								
	ē	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b.		as a cons	uence of):								
is alth	=	cause. Enter Underlying Cause (Disease or injury	<											
xecu	Examiner	that initiated events resulting in death) Last	c.	Due to (or	as a consec	uence of):	_							
3760, at the best of the purish and the burial-transit	cal		€.											
687 tificate g phys			0.											
certification of the second of	N N	IF FEMALE:	23	lc. If yes, outcon	ne of pregna	ancv							12d Date of delice	
BOX 68 death certificat e ettending phy d for use as th	lan	23b. Was decedent pregnant in the past 12 months?		1 ☐ Live birth 4 ☐ Pregnant	2 ☐Feta	ldeath 3□	Ectopic pr Other (sp					4	3d. Date of delive: Month	Day Year
. 0 0 0 1	Physician/Med	1 ∐ Yes 2 S⊄No 9		9☐ Unknown		eau 5	) Other (sp	ecity)						
	2	Part If. Other significant conditi	ons cont	inbuting to death	but not res	ulting in the ur	nderlying c	ause give	en in Part I.		23e. Did to	bacco u	se contribute to t	ne cause of death?
0 8 2 8	6	V-4-						•				es 2[		
cord	Completed							-			040 1450		0.4h 14/4	
has has	E I										24a. Was a autop	SY	prior to co death?	psy findings available mpletion of cause of
												2/ZPNo	1 Yes	2 🗆 No
of Vital F Physician: Th this certificate ral director, pag	ge	25. Was case referred to medica examiner?	_	ospital:				100		of Death	(Check only or	ne)		
A side	2	1 Yes 2 Who		1 7 inpa		ER/Outpatien			4   140				Other (Specif	y)
On of	0	27. Manner of Death 1		28a. Dale of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury		8c. Injury Work	(?		8d. Describe h	ow injury	occurred	
Vision Attending r death. ector: After	cat	2 Accident investi	-				М		res 2 🗆 l					
Division I or Attending after death. Director: Afte	Certification	4 Homicide determ		28e. Place of building,	Injury - At h etc. (Specii	ome, farm, stri (y)	eet, factory	, office		2	81. Location (S City or Tow		d Number or Rura	I Route Number,
Hospital or 44 hours after Funerel Dir tely filled in		29a, Certifier 1 <b>Yeartifyi</b> r	a Physi	ician: To the he	et of my kno	wiladaa daath		at the time	a data an	d =10== =		(-)		
Divi	Medical	(Check only 2 Medical one)	Examin	er: On the basis and manner	of examina	ition and/or inv	estigation	, in my op	oinion, deal	d place, a th occurre	nd due to the d at the time, o	ause(s) ate and	and manner as s place, and due to	tated.  the cause(s)
To th within To th comp	Me	29b. Signature and title of certifie	r				290	. License			2	9d. Date	e signed (Month,	Day, Year)
		MI +	K.					Ro.	5-0	00		A	6) 1 2	2006
	-	30. Name and address of person	who cor	nnleted cause of	f death /Ito:	n 23a) /Tune	Print\ .Tz				2 27777 27-	/ 17 Mail	1	
10		<b>T</b> 11 11.	yat			200) (1ype,			nopk. asteri				ical Cti re, MD	21224
Stat	e_	31. Date filed (Month, Day, Year)		~(4)	strar's Signa	ature					Dal	-1110	-C, ED	C1267
Registra		APR 0.3 2	2006	Regies	, K	Loca	(e)							

DHMH 17 Rev 1/2001

			1 - For Registrar	State of Marylar		artment of H			giene Reg. No.	006	10189
	Dhysisi	-	1. Decedent's Name (First, Middle, Las	1)				2. Date of Dea Month		. 2000	3. Time of Death
	Physici /Medi		Frank Coo.		alters						
je.	Examir	ner	4a. Facility Name (If not institution, give Saint Joseph	street and number) Medical Cen	ter	4b. City, Town, or		eath 75011	4c.	County of Deat	timore
	Funeral		Social Security Number     6. Security Number	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 H	lin. (Month. Da	v. Year)	Co	hplace (State or Foreign untry)
	Director		248-32-0399 " Usual Residence of Decedent	80	Yrs.			8/29/	192	5 Nor	th Carolin
	land ow		10a. State 10b. County	10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
	Mary First	ģ	Maryland Baltimor	e Ess	Σχ						1 ☐ Yes 2 🛣 No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Co	untry?
	ath w		166 Bennett Road			21221				S. A.	
	er de	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces? 1 MYes 2 □ No	J.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	' (Specify Yes or No- uerto Rican, etc.)	.   '	14. Race - Ame Black, White	
36	irs aft	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW	тт	1 ☐ Yes 2 💆 No	Specify:			Specify: Wh	ite
Š	within 72 hours after death with the Maryland ene. then "naturel", or terms 23a or 28a-f show the Modical Exerciting fault be notified at	ted	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occup	ation	adiaa	16b. Kir	nd of Business/	
21	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	during most or	working			
Maryland 21215-0036	filed w Hygier other th		12 17. Father's Name (First, Middle, Last)		Mach:	inist	10 Mahada	Name (First, Middle,			and Seal
ano	d be fi	Be		14						Sumame)	
2	should Ind Men	2	Frank Lamarr Wa 19a. Informant's Name/Relationship (7)		19b. Maili	ng Address (Street		Gregory  Rural Route Number		Town, State, Z	(ip Code)
S	nd 2 salth ar alth ar 27 ts r treu		Frank Duane Walte	1000 00	P.O.	Box 190	White	Marsh, Ma	rvla	nd 2116	52
altimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20b.	Place of Dispo	osition (Name of matory or other place	- 1	Date	_	cation - City or	
Ĕ	Page nent of ant: #		4 □ Donation 5 □ Other (Specify		yview (	Crematory	20	006	Balt	imore,	Maryland
Balt	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny Injury or other tree		21. Signature of Funeral Service Licen	500	B.	2. Name and Addre	ss of Facility				
	40 = • a		Muchael C.	Jaffran SI	7	ruzdzinsk 407 old E	astern	Avenue E	ssex	, Maryl	and 21221
>	Physician		23a. Part1. Enter the disease, or copy shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	INTRAVENT					1651,		Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions,	Due to (or as a consec SEFSIS b.							
	ed sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						Ì	
	axecul and al-trar	Examiner	that initiated events resulting in death) Last	Due to (or as a consec							
8760,	icate be executed physicien and s the burial-transit	dicail	· ·	d							
9	ntificat ng phy as th	Medi	IF FEMALE:								
О. Вох	is death certificate be executed the ettending physicien and hed for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3[	Ectopic pregnancy Other (specify)	<i>'</i>		2	3d. Date of deli Month	ivery Day Year
۵.	The law requires that the de ate has been signed by the e bage 2 should be detached (	/ Ph	Part II. Other significant conditions of	entributing to death but not res	sulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco u	se contribute to	the cause of death?
Records,	quires n sign ald be	d by						101	es 25	No 3□Pro	obably 4 Dunknown
000	aw requir s been si 2 should	Completed						24a. Was		24b. Were au	topsy findings available completion of cause of
ž		E						— autop perfo	med?	death?	2 No
Division of Vital	ysicien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?					Death (Check only o	ne)		
5	Physi this c al dire	5	1 ⊔ Yes 200 No		ER/Outpatie			g Home 5 ☐ Resid			cify)
5	ding f	tion	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ∐ No	28d. Describe h	iow injury	occurred	
18	Attending Physicien: r death. ector: Atter this certification the funeral director, it	fical	3 ☐ Suicide 6 ☐ Could not be	288. Place of injury - At n	iome, farm, st		103 2010				ıral Route Number,
É	al or a after ii Dire	Certification:	4 Homicide	building, etc. (Speci	<b>(y</b> )			City or Tou	m, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicaf Exam	ysician: To the best of my known iner: On the basis of examination and manner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and pl pinion, death o	ace, and due to the occurred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	$\cap$		29c. Licens			29d. Date	signed (Month	n. Qay. Year)
1	. 1		leballo	m		D25	886	(	1pm	il 13	2006
1	101		30. Name and address of person who o			•	Traine	M MADVI	ONES	21204	
Ĭ	Sta	le.	LILIA CEBALLOS  31. Date filed (Month, Day, Year)	3 M. D. 76 Ø 1		LA DRIVE	I LIWEL	ON MARYL	mi VII./	EL 1 EL (C(*)	
	Regist		APR 0 3 20		1 AM	West !					

DHMH 17 Rev 1/2001

			State of Maryland / Department of Health and M  State Certificate of Death		giene Reg. No:	06	10190
			Decedent's Name (First, Middle, Last)	2. Date of De		Vasa	3. Time of Death
	Physici /Medio		Lorraine Irene Wingle	Month O	3)	2006	12:30 PM
	Examin		4a Eacility Name (If not institution, give street and number).  4b. City, Town, or Location of Death  Franklin Sallare Horizotta		4c. Count	y of Death	vore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bir (Month, Da	th	9. Birthpla	ace (State or Foreign
	Director		204-20-8589 10 M 21AF 86 Yrs.	1/29/1	920		ylvania
	laryland show		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10	d. Inside City Limits
	Many Many	tor	Maryland Baltimore Essex				1 ☐ Yes 2 🖔 No
4	or 28a-1	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Count	ry?
1	death with the Maryland rms 23s or 28s-1 show rms: Le nullised si	rail	36 Wagners Lane 21221		U.S.		
)	ltsmy	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	ecity Yes or No Rican, etc.)	)- 14. Ha Bla	ice - America ack, White, e	
JV -	hours after turs!, or Its	þ	If Yes, Give 1 ☐ Yes 2X No Specify: Year or Dates:		Spec	ity: Whit	e
20-5	72 hours after dea "neturs!', or itsms	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	ing	16b. Kind of I		
7 (121	within ene. then	mpi	Elementary/Secondary (0-12) College (1-4or 5+)				
\$ p	filed v Hygie other t	S	4 Homemaker  17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle,	Own H , Maiden Suma		
and	ould be Mental arked o	To Be	Albert Schwartz Carol	Eckler			
گ <sub>ر</sub> م	Share and	-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run		er, City or Town	n, State, Zip (	Code)
> ≥	tem 27 l			ex, Mar			
	permit. Pages 1 and Department of Health Important: If item 27 sny Injury or other tr once.	1	1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State	Date 4/4	20c. Location		
Altim	artmen ortsnt: Injury	1 5	4 □ Donation 5 □ Other (Specify)  Bel Air Memorial Gardens  21. Signature of Funeral Service Licensee  22. Name and Address of Facility	4/4 2006	Bel Ai	r, Mar	yland
B	permit. Departr Imports sny Inj		Michael C. Jakkow 50 Bruzdzinski Funera 1407 old Eastern A	l Home : venue	PA Essex,	Marvla	nd 21221
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
11		er	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury				
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
,00	ate be executed hysicien and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
8760,	cate be ex physicien the buria	dicai	d			-	
9 x c	eath certifi ettending p for use as	√Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. D	ate of deliver	v
Box.	ette for	by Physician/Me	in the past 12 months?  1 Yes 2 No  1 Ves 2 No		1		Day Year
P.0	thet the de ed by the detached	Phys	9 □ Onknown	22a Did	school was as	etalbuta to the	cause of death?
Division of Vital Records, P.O.	signed be de	d by	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236. DIO 1	_		bly 4 [Unknown
cor	w requir been s should	ete		24a. Was		. Were auton	sy findings available
Re	The lav te has age 2	Completed		auto	ormed?	prior to com death? 1 \( \text{Yes} \) 2	sy findings available pletion of cause of
ital	ician: Th certificete rector, pag	BeC	25. Was case referred to medical examiner? 26. Place of Deat	1 ☐ Yes h (Check only o	24 No	10165	2 140
, , ,	Physic this ce al direc	၉	1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho				
o uo	tanding Physician: The feath. tor: After this certificete his the funeral director, page	tion:	27. Manner of Death  1—Natural 5   Pending (Month, Day Yeer)  28a. Date of frijury (28b. Time of Injury Work?  1 — Natural investigation   M M   1   Yes 2   No	28d. Describe	how injury occu	ırred	
/isfo	al or Attandir atter death. I Diractor: Af d in by the fu	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office			nber or Rural	Route Number,
Div	rs after al Dira ed in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or To	wn, State)		
	To the Hospital or At within 24 hours after or To the Funaral Direction place of the Funaral Direction by the Funaral Fulled in by	Medical	29a. Certifier  (Check only one)  (Check	and due to the red at the time,	cause(s) and n date and place	nanner as sta i, and due to	ited. the cause(s)
		Me	29b. Signature and tiple of certifier 29c. License number		29d. Date sign	ed (Month, D	Jay, Year)
	h		MP (ARIESTLEY) RES ODOOL	)	3-	31-0	X0
	18		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Drivo	By Hi	mayo 1	10 11227
	Sta	at <u>e</u>	31. Date filed (Month, Day, Year) 32-Registrar's Signature	UI IVE	UMIL	11014	1 W W D J 1
	Regist		APR 0 3 2006				

			1 - For State Registrar	State of Maryland	-	artment of tificate of			giene Reg. No.	06	10191
ľ	Physici /Medic		Decedent's Name (First, Middle, Last)     Branden Lee	Wigfield, Sr				2. Date of De Month April	Day 1, 2006	Year	3. Time of Death  10:08 am
	Examin		4a. Fecility Name (If not institution, give 32 Stabilizer Driv	street and number)		Middle	or Location of Dea River	th	Balt	ty of Deatl	h e
	Funeral Director		5. Social Security Number 6. Security Number 213–36–1605  Usual Residence of Decedent	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days			av Year)	9. Birti Co Per	nplace (State or Foreign untry) nnsylvania
	e Maryland la-f ehow	ctor	10a. State 10b. County  Maryland Baltimor		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2X No
:	permit. Pages 1 and 2 should be lited within 72 nours after death with the Maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. The mary is marked other than "natural" or iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examiner must be notified at once.	Funeral Directo	11. Maritar States	12. Was Decedent Ever in U.S Armed Forces?	S. 13. \	10f. Zip Code 21220 Was Decedent of f Yes, specify Cu	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	10g. Citizen o	Α	rican Indian,
21213-0030	"natural", or	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: cation e completed)	16a. Deced	dent's Usual Occu	ipation during most of w	orking	Spec	W	nite Industry
7 7 7	e liled within al Hygiene. I other than vent, to Me	Be Completed	Elementary/Secondary (0·12) 10 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	Carpe	nter	,	ıme (First, Middle			Construction
Maryland	12 should be nand Mental   I is marked o	Tof	Melvin Wigfield  19a. Informant's Name/Relationship (Ty		170		at and Number or F		er, City or Tow		
Dallillore, I	Pages 1 and nent of Health int: If Item 2 iry or other i		Madeline Florence  20a. Method of Disposition  1 XBurial 2 Cremation 3 F  4 Donation 5 Other (Specify)	20b. Pla Removal from State	ace of Dispo metery, crer	Stabiliz esition (Name of matory or other pl of Faith	er Drive	Middle Date 74 006	20c. Location	n - City or	yland 21220 Town, State Maryland
Daite	permit. P Departme Importer eny Injur		21. Signature of Funeral Service Licens	Saffras Sr	22 Bi	2. Name and Add ruzdzins 407 Old	ess of Facility ki Funer Eastern	al Home Avenue	PA Essex,		land 21221
	Physician /Medical Examiner	ي	23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	identifies that caused the death, ne cause on each line.  Due to (or as a consequence).  Due to (or as a consequence).	ence of):	Never.	. /		arrest,		Approximate Interval Between Onset and Death
,00,0	The law requires that the death certificate be executed to the best signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent.							
	that the death certificated by the ettending placed by the ettending placed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnan  1 Live birth 2 Fetal  4 Pregnant at time of de	death 3	Ectopic pregnan Other (specify)	су			Date of deli Month	ivery Day Year
,	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	ntributing to death but not resul	lting in the u	nderlying cause g	iven in Part I.		tobacco use co	ontribute to 3 ☐ Pr	the cause of death?
)	: The law re cate hes bee page 2 sho	Completed	Hypertensión Hypertroidemia					24a. Was auto peri 1 Yes	s an 24b ppsy ormed? 2XNo	prior to death?	atopsy findings available completion of cause of 2 No
	To the Hospital or Atlending Physician: The I within 24 hours after death. To the Funeral Director; After this certificate he completely filled in by the funeral director, page:	n: To Be	25. Wa ase ref rred to medical examiner?  1 ☐ Yes 2 ☐ XNo  27. Manner of Death  1 ☐ XNatural 5 ☐ Pending	-	ER/Outpatier 28b. Time o Injury	f 28c. Inj	ther: 4 Nursing	Home 5 A Res 28d. Describe			cify)
-	l or Attendir after death. Director; Al I in by the fu	Certification:	2 Accident 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, str		Yes 2 No		(Street and Nur own, State)	mber or Ru	ural Route Number,
	he Hospital in 24 hours a he Funeral i pletely filled	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, deat ion and/or in	h occurred at the vestigation, in my	time, date and place opinion, death oc	ce, and due to the curred at the time	cause(s) and a date and place	manner as e, and due	stated. to the cause(s)
	To the within 2 complete	Σ	29b. Signature and title of certifier    husling Blue   Common of the co	lula no	220) (5:	AJ Y	147 <i>3</i> 57 -	77089	April	3, -	h, Day, Year) 2006
+	√ Sta Registi		30. Name and address of person who con the state of the s	Y JOHNS Hol 32. Registrar's Signati	WN3	HOSBITAL	1550 (	DRLEANS	S SVITE BAL	TIMO	16 RE, MARYUAN 212

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 Month Year **Physician** March 30, 1:30  $A^{M}$ Neil Harper Wheeler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gaithersburg Wilson Health Care Center Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1∭M 2□F 578-20-6255 Yrs. Director 84 October 7, Arizona Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "naturel", or Iteme 23e or 28e-f show traumatic event, the Mcdical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20878 14512 Triple Crown Place United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 1945 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. I hours after important: If Item 27 is marked other than "naturel", or Item any Injury or other traumatic event the 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Executive Bank Officer Banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles DeSales Wheeler Nancy Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon E. Cohen/daughter 14512 Triple Crown Place, Gaithersburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 2, 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland Propert A. Pumphrey Funeral Home, Rockville, Inc. W. Montgomery Avenue, Rockville, MD 20850 21. Signature of Funeral Service Licensee Milliam a. Kenplines M01173 300 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lacleire JULERA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 47 ayea 60 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Phursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3∏ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 🗌 Yes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) DO4115 1 & Robert Brachbaddel) 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) 20; RUSSELL 4 VENCLE 14. ROBERT BIRSCHBACH, RUD GAITHERSBURG, RD 20 10+1 31. Date filed (Month, Day, Year) APR 0 3 2006 Registrar

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

APR 0 3 2008

32. Registrar's Signature

			1 - For State Registrar	State of Man		artment of F rtificate of			Reg. No.	10194
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of De	Day Year	3. Time of Death
	/Medic		MARIUYN .	ZIMMER	LE			FEB	27 2006	3 10 AM
	Examir	er	4a. Facility Name (If not institution, give Howard County Ger	e street and number) neral Hospit	al	Co	Location of Death		4c. County of Deat	i
	Funeral Director		5. Social Security Number 022–40–7269 6. S	ex	n yrs. last birthday 55 Yrs.	Months Days	Hours Min.	(Month, Da	th by, Year) 9. Birt Co 26/50	hplece (State or Foreign nuntry) NJ
	p		Usual Residence of Decedent							
	Marylan -{ show	tor	MD 10b. County	arroll	Oc. City, Town or L		dbine			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the sa or 28e	I Direc	10e. Street and Number 3120 Lorenzo Lane	<u> </u>		10f. Zip Code 217	97		10g. Citizen of What Co USA	ountry?
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23a or 28e-f show other traumatic event, Ita Madical Excitation roust be indiffied at	by Funeral Director	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	or in U.S. 13	Was Decedent of H If Yes, specify Cubin	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	ithin 72 ho ie. ien "natur ien "natur	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done DO NOT use retired	during most of word)		16b. Kind of Business/	
2	fited within Hygiene. Ithar than "			4		AHCIG	ue Deale		Antique Sa	ites
Maryland	12 should be fited within h and Mental Hygiene. Fis marked othar than "traumatic evant, tra Men	To Be	17. Father's Name (First, Middle, Last) John A. McNamara				Mary O		, Maiden Surname)	
ary	2 shou and h is ma is ma	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mai	ing Address (Street	and Number or Ru	ıral Route Numb	er, City or Town, State, 2	Zip Code)
	1 and 2 Health am 27 i		Alan Zimmerle / H			Lorenzo	Lane, Woo			
Baltimore,	Pages 1 ar nent of Hea nt: It itam rry or otha		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specification of the content of the conten	Removal from State	20b. Place of Disp cemetery, cre Holy Cr	osition (Name of ematory or other place OSS Cemet	ery 3/4	Date / 2006	Malden, M	Town, State [A
Balti	permit. Pages Department of the Important: It its any injury or of once.		21. Signature of Funeral Service Licer			Charles	L. Stever	ns Funer	al Home, In	c.
	.8		23a. Part1. Enter the disease, or com	plications that caused the	death. Do not er	1501 E. nter the mode of dyir	Fort Ave	Baltimo or respiratory a	re MD 21230 rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. SEPTI		OCK				Onset and Death  2 0745
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a co						3 0245
	suted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
9	tificate ng phys as the	edic	`	d				-		
O. Box	The faw requires that the death certificate be executed tee base signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	/		23d. Date of del Month	ivery Day Year
۳.	s that ned b e deta	by Pt	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
rds	quires an sign uld be		MGTASTATIC	BREAST C	MNCER			10	Yes 2□No 3□Pr	obably 4 Donknown
Vital Records,	The law requate has been page 2 shoul	Completed							prior to death?	topsy findings available completion of cause of
tal		ø	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only o	2 TerNo 1 ☐ Yes	2 No
	diis	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Impatient	2 ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing H	lome 5 🗆 Resi	dence 6 Other (Spec	cify)
ion of	Jing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time Injury	Wor	y at k? Yes 2 □ No	28d. Describe	how injury occurred	
Division	Fi Pi fe	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (S		treet, factory, office		28f. Location ( City or To	Street and Number or Ru wn, State)	ıral Route Number,
	spite ours naral filled	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of m niner: On the basis of exi and manner stated	amination and/or i	th occurred at the tin	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
•	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier	youpon		29c. Licens	6974		29d. Date signed (Month	2006
	2		30. Name and address of person who	completed cause of death	h (Item 23a) (Type	Print) PAUXONT	6974 PKWY	Corum	BIA MO	21544
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's						· · · · · · · · · · · · · · · · · · ·
DH	MH 17 Rev 1/2		APR 0 3 200	6 Mensie	II Figure					

		1. Decedent's Name (First, Middle, Last)  For Amend Item/19a State of Manufand (Dep. 197)  State	tment of Health and Mer tupes of Death	ntal Hygiene Reg. No. 0 6 1 0 1 9 5  Date of Death 3. Time of Death
Physi /Med	dical	James D. Ziegler		Month Day Year arch 18, 2006 3:55 AM M
Exam	H	7005 York Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore	Baltimore  Date of Birth (Month, Day, Year)  Date of Birth (Country)  9. Birthplace (State or Foreign Country)
Directo		542-30-8142       1		(Month, Day, Year) ug 20, 1928 Oregon  10d. Inside City Limits
ire, Marrylaria z 1 z 1 2 - 20030  s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28a-f show other traumatic event, the Medical Examinal must be routhed.	by Funeral Director	MD   Baltimore	Ore  10f. Zip Code  21212  Nas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rici	1 Tyes 2 No  10g. Citizen of What Country?  USA  (Yes or No- an, etc.)  14. Race - American Indian, Bleck, White, etc.  Specify: White
ed within 72 hours after bygiene. Ier then "natural", or Ite t. Ite Medical Exercise	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 Coll	tent's Usual Occupation kind of work done during most of working DO NOT use retired) .ege professor	18b. Kind of Business/Industry  education
2 should be filed and Mental Hygier Is marked other aumatic event.	To Be	17. Father's Name (First, Middle, Last)  Herman Ziegler	Robbie Be	irst, Middle, Maiden Sumame)  ryl Eslinger  oute Number, City or Town, State, Zip Code)
Daltimore, Inca bermit. Pages 1 and 2 st Department of Health and mportant: M Item 27 Is n my injury or other traum		Dorothy Ziegler/spouse 7005  20a Method of Disposition 20b. Place of Dispo	York Road Baltimore	, MD 21212
Dartimore permit, Pages 1 Department of H Important: # ite any injury or oti	DUCE	21. Signature of Service Licensee Wade, Director Service Bonal do Wade, Director Be	1timore, MD 21201	55 W. Baltimore Street
Physicial (Poor)  (Poor)  Physician and (Poo	al er	resulting in death)  Due to (or as a consequence of)  Sequentially list conditions, if any leading to immediate  Due to (or as a consequence of):	er the mode of dying, such as cardiac or re	Approximate Interval Between Onset and Death  2 mm/h
hat the death certificate be executed that the attending physician and detached for use as the burial transit	Physician/Medic		Ectopic pregnancy Other (specify)	23d. Date of delivery  Month Day Year
8 6 8	2	Part II. Other significant conditions contributing to dealth out not resulting in the c	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
The law ate has b page 2 si	Completed			24e. Was an autopsy performed?  1 Yes 2 No 2 1 Yes 2 Y
Phy C	F C	1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie  27. Manner of Death   28a. Date of Injury (Month, Day Year)   28b. Time of Injury (Month, Day Year)	28c. Injury at Work?  M 1 Yes 2 No	5 X Residence 6 Other (Specify)  1. Describe how injury occurred  Location (Street and Number or Rural Route Number,
DIVISION To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune			n occurred at the time, date and place, and	City or Town, State)  I due to the cause(s) and manner as stated.
To the H within 24 To the Fi	Modi	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deal of the basis of examination and/or in and manner stated.  29b. Signature and title of certifier  29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
( Regi	State		Thales ST BAL	3/24/86 The MO 21264

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

					,	Certifica	ate of	Death		Reg. No.	16	10196
	Dhysisi		1. Decedent's Name (First, Middle, Last	-		1 1			2. Date of De Month	eth Dey	Year	3. Time of Death
-	Physicia /Medic		William	$\in$		Hndruson	\		March		3006	1575
	Examin		4a Fecility Name (If not institution, give	street end number)				4b. City, Town, o	r Location of Deet	h 4c. Count	of Deeth	
			AUGSBURG LUTHERAN					BALTIM			1	
	Funeral Director		5. Social Security Number  220-05-0167  Usuel Residence of Decedent	7. Age	85	est birthday) If Und Month	der 1 Year is Days	Hours Mi		th ay, Year) 1920	9. Birthp Coun DC	place (Stete or Foreign htry)
	and w	ŀ	10a. Stete 10b. County		10c. City	, Town or Location					1	Od. Inside City Limits
	Mary!	ō	FL LEE		FOR	T MYERS						1 ☐ Yes 2 No
	28. 10.	Director	10e. Street end Number		FOR		Zip Code			10g. Citizen of	What Cour	ntry?
	3a o		12721 MEADOW PINE	T.ANE		3	3913			USA		
	death	Funeral	11. Maritet Status	12. Was Decedent E	ver in U,	S. 13. Was De	cedent of h	dispanic Origin?	(Specify Yes or No	- 14. Ra	ce - Americ	
21215-0020	s 1 end 2 should be filed within 72 hours after death with the Maryland if Heelth end Mantal Hygiana. Item 27 is marked other than "natural, or items 23a or 28a-f show other traumatic event, the Madical Exandrer must be notified at	ρ	1 ☐ Never Married . 2 💥 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 □ N If Yes, Give Year or Dates:	。 WWII	1 □ Yes		an, Mexicen, Pue	erto Hican, etc.)		ick, White, fy: WHI	
5-0	72 ho	Completed	15. Decedent's Edu (Specify only highest gred	cation		16e. Decedent's U	sual Occup	oation during most of w	rorkina	16b. Kind of E	usiness/In	dustry
21	within ana.	nple	Elementery/Secondary (0-12)	College (1-4or 5-	+)			during most of w d)	g			
2	Hygiar Hygiar Wher th	S	12			ENGINEER		45. 14. 11. 1. 1. 11		INDUST		
ī	tal H d off	Be	17. Father's Neme (First, Middle, Last)						ame (First, <b>M</b> iddle	, Maiden Surnai	nej	
3	should bind Mant marked umatic e	ဥ	CLEMENCE GARLAND				(0)		POSTEN	O't T	Ctata 7:	Code
Maryland	12 sho h end r is me traum	- 1	19a. Informant's Name/Relationship (T)			19b. Mailing Addre						
	s 1 end 2 of Heelth item 27 i		MARK ANDERSON / So 20a. Method of Disposition	ON	20h Pi	470 PLAN	Jame of		Date	20c. Location		
Baltimore,		į	1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	1	CHÉ	SAPEAKE C TER, LLC.	r other pla REMAT		MAR. 16 2006		_	
Ball	permit. Page Depertment of Important: if any injury or once.		21. Signature of Funeral Service Licens	000	7	FELLO	WS, F		IN & NEWI		ERAL F	HOME, P.A.
	STATE OF		23a. Part1. Enter the diseate, or compleshock, or heart failure. List only of	lications that caused	the death							Approximate Interval Between
-	Physician		Shock, of healt failure. List only o	ne cause of eech in	0.	6					į	Onset and Death
71	/Medical		Immediate Cause (Final disease or condition	_			-Une	, Car	ncer			1 year
0.	Examiner		resulting in death)	j	Due to (or	as a consequence of	of):	7			I	
	P #	lue		h							<u>'</u>	
	The law requiras that the death certificata be executed ate has been signed by the attending physician and page 2 should be detached for use es the bunal-transit	Examiner	Sequentially list conditions,		Due to (or	as a consequence of	of):					
60,	be ex cian burial		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that is littled graph of the conditions  if the conditions of the	c								
68760,	cata physi the	edical	that initieted events resulting in death) Lest		Due to (or	as a consequence of	f):				-	
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Вох	eath ce attendi	clan										- M
P.0.	hat tha death ce ed by the attend detached for us	Physician/	Part II. Other significant conditions con	tributing to deeth bu	t not resu	Iting in the underlyin	g cause gr	ven in Part I.		Yes 2□ No		o the cause of death? bably 4 Unknown
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tal		Be	25. Was case referred to medical				-	26. Place of D	eath (Check only		1	
>	Physician: The li this certificate ha	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier	nt 2 🗆 I	ER/Outpatient 3	DOA OII	oor:	Home 5□Res		her (Specil	fy)
	£ £ m	tion: T	27. Manner of Deeth  1 Naturel 5 Pending	28a. Date of Injun (Month, Dey		28b. Time of Injury	28c. Inju Wo			how injury occu		
Division	if or Attending Peter death.  Director: After to in by the funer.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc.	ry - At ho . (Specify	me, farm, street, fac	ory, office			Street and Num wn, Stete)	ber or Rura	al Route Number,
	To the Hospital or Atl within 24 hours efter d To the Funeral Direct complataly filled in by	edical Ce	29a. Certifier (Check only 2 Medical Exam)	sician: To the best of	f my knov examinati	vledge, death occurr ion end/or investigati	ed at the ti	me, date end pla	ce, and due to the	cause(s) and m	anner as s	steted. o the cause(s)
	To the H within 24 To the F complate	8 N	one)	and manner stat			29c. Licens			29d. Date sign		
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			<b>Y</b>	$\times$				N 212	1 -2	Man	ch 1	2,006
			30. Name and address of person who co	MIN	35 1	Main 5	t, '	Reister	ren 1	10 -	21136	7
*	Sta Registr		31. Date filed (Month, Day 197)	2006 Register	r's Signat	ture # A	ale					

		For	Please	Type or Prin State of Ma		Depa	artment of H	Health a		-	_	
Physic		1 - State Registrar  1. Decedent's Name JUAN CA		st) ARES, JR.		Cer	tificate of	Death	N	Page of Death	Day Year	3. Time of Death p
/Medi Examii Funeral		4a. Facility Name (I Washingt 5. Social Security N	on County Jumber 6.5	re street and number) y Hospital	e (In yrs. last b	nirthday) Yrs.	4b. City, Town, of Hag If Under 1 Year Months Days	gersto	of Death  WIN  24 Hrs. 8. D  Min. (A	pate of Birth	4c. County of Deat  Washing  (ear)  9. Birt  Co	h ston hplace (State or Foreign untry)
Director • • • • • • • • • • • • • • • • • • •	or	220-15-80 Usual Residence of 10a. State Indiana	f Decedent 10b. County	lark	40	wn or Lo			Fe	eb. 3,	1966   Arg	10d. Inside City Limits
th with the N 23a or 28e-f	al Director	10e. Street and Nu			Mem	phis	10f. Zip Code	7143		100	g. Citizen of What Co USA	untry?
ours after dea rai', or tteme	by Funeral	11. Marital Status  1 Never Marr  3 Widowed	ied 2⊠ Marned 4 □ Divorced	12. Was Decedent I Armed Forces? 1  Yes 2 In If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cub			Yes or No- n, etc.)	14. Race - Ame Black, White Specify:	
d within 72 ho giene. or than "natu	Completed	(Spec Elementary/Seco 12	15. Decedent's E cify only highest gr ondary (0-12)	ducation ade <i>completed)</i> College (1-4or 5	i+)	(Give life. L	dent's Usual Occup kind of work done DO NOT use retire	during most	t of working	16	Satellit	
hould be file d Mental Hyg marked oth matic event,	To Be C		(First, Middle, Last rlos Acia ame/Relationship)	ares, Sr.	19	h Mailin	ng Address (Street	]	Lidya (	Carpena	aiden Surname) Zano City or Town, State, 2	₹ip Code)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatith and Mental Hygiene.  Importent: If item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other traumatic event, the Medical Examinat must be rivilified at once.		Mary Ac	iares - v	•	20b. Place	112 of Dispo	- 1	w Driv	ve, Men	nphis,	Indiana 4	7143
permit. Pa Departmen Importent: eny injury		4 □Donation 21. Signature of Fit	5 □ Other (Special Service Lice		Hager	12	wn Cremat 2. Name and Addre 15 E. Wil	ess of Facilit	3/21/00 MINNI	CH FUN	a erstown ERAL HOME town, Md.	Maryland 21740
Physician /Medical		23a. Part1. Enter t shock, or hea Immediate Cause disease or condition resulting in death)	art failure. List <i>o</i> nly (Final on	plications that caused one cause on each ling a. Due to (or as	the death. Done.	oti			cardiac or res			Approximate Interval Between Onset and Death
rificate be executed Trificate be executed Trificate by sicien and Trificate by as the burial-transit Trificate by the part of the burial-transit Trificate by	icai Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	r injury	c	a consequence		thy					5 yrs
The law requires that the death certificate be the law requires that the death certificate be the base been signed by the attending physicis agge 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 0	? months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal deal		□Ectopic pregnanc □ Other (specify) _	ey .			23d. Date of del Month	ivery Day Year
v requires that I been signed by	by	Part II. Other signi	ficant conditions	contributing to death b	ut not resulting	j in the u	nderlying cause gr	ven in Part I.			acco use contribute to : 2 ☐ No 3 ☐ Pr	the cause of death?
	e Completed	25. Was case refe	rred to medical					26 Place			ed? prior to death?  No 1 □ Yes	utopsy findings available completion of cause of 2 No
physicle this cert al directi	To B	examiner?	] No	Hospital:			IL SLI DOA	her: 4 □ Nu	ırsing Home	5 ☐ Residen	ce 6 □Other (Spe	cify)
ng r	Certification:	27. Manner of Deal  1 Statural 2 Accident 3 Suicide 4 Homicide	5 Pending investigation 6 Could not to determine	De Bloce of Init	y Year) ury - At home,	Time of Injury farm, str	Wo	Yes 2 🗆	No 28f. L		v injury occurred  eet and Number or Ro State)	ural Route Number,
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the it.	edical Cer	29a. Certifier (Check only one)	1 Certifying P	hysician: To the best miner: On the basis of and manner sta	f examination a	ge, deati and/or in	h occurred at the t vestigation, in my	ime, date an opinion, dea	nd place, and o ath occurred at	due to the cau	use(s) and manner as te and place, and due	s stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and	AD mo	OME		1.6	D .	se number	65	29	d. Date signed (Mont	h, Day, Year)
OH-5		Dr.	Kotch	completed cause of d	st an	tut	Print)	L.	Ang.	md.	21740	
St Regist	*	31. Date filed (Mor	MAR 21	2006 32. Registr	ar's Signature	S	redis					

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

				State	or mary		epartifica Certifica		Death		Reg. No.	6 1	010	36
	Dhysisis	3	1. Decedent's Neme (First, Mic							2. Dete of De		Year	3. Time of I	
100	Physicia /Medic			A. BRITT		SR.				Month /1		1-	3:13	3 PM
(	Examin	er	4e Facility Neme (If not institut		I number)				4b. City, Town, or Lo		Worce			
			1507 Cedar S  5. Social Security Number	6. Sex	7. Age (In y	re last hirth	dev) If Un	der 1 Year	Pocomok  If Under 24 Hrs.				ce (State or	r Foreign
	Funeral Director		217-14-8690 Usuel Residence of Decedent	120 M 2□I			rs. Month		Hours Min.	8. Date of Birl (Month, Da 11/27	y, Year) /11	Counti MD	ice (State or y)	
	puel #		10a. Stete 10b. Cour	nty	10c.	City, Town	or Location					10	d. Inside City	y Limits
	Mery	į	MD Wo	orcester		Pocomo	oke						1 ☑ Yes	2 🗆 No
	or 284	Se l	10e. Street end Number				10f.	Zip Code			10g. Citizen of V	Vhet Count	y?	
	23a vi	lal	1507 Cedar S					21851			USA			
020	filed within 72 hours efter deeth with the Meryland Hygiene. ther than "naturel", or flems 23a or 28e-f show ont, fire Medical Examiner must be notified at	by Funeral Director	11. Maritel Status  1 Never Married 2000 3 Divorce	arried 1 Ye ff Yes.	Decedent Ever in id Forces? es 2 A No , Give or Detes:	n U,S.			lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes <i>o</i> r No Rican, etc.)		e - America ek, White, e :: Blac	tc.	
Maryland 21215-0020	in 72 ho	Completed	(Specify only high	lent's Educetion hest grede complete		16a. [	Decedent's U (Give kind of life. DO NO	suel Occup work done Fuse retired	eation during most of work d)	ring	16b. Kind of Bu	ısiness/Indu	istry	
212	be filed withintel Hygiene. Ind other than event, the M	E O	Elementery/Secondary (0-12	) Colleg	je (1-4 or 5+)		aborer				Feed			
b	should be filed nd Mentel Hygi marked other imatic event, I	Bec	17. Father's Neme (First, Midd	le, Last)					18. Mother's Nam	e (First, Middle,	Maiden Sumem	10)		
<u>ya</u>	2 should be t end Mentel I is marked of eumatic eve	2	Daniel Britt	ingham							Britti			
Mar	S 0 0 0		19a. Informant's Name/Refetio			19b.	_	•	and Number or Rur		-		iode)	
	Heal Heal	-	Barbara Whit	e, baugn		b. Place of I	Disposition (/	Vame of	St., Poo	Date Date	20c. Location -		n. State	
Baltimore,	permit. Pages 1 e Depertment of Hee Important: If item any Injury or othe		12 Burial 2 ☐ Crematio 4 ☐ Donetion 5 ☐ Other		om State	cemetery	nes Ce	or other ple		3/25/06	Pocom	-		
3alti	Depentit. Depentit Importa any Inju		21. Signature of Funer	i se	11		1900		ss of Facility	E: SEV	742 F2		Paul P	
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1	Physician		23a Fert I. Enter the Jseese, shock, or he rt Filure. L										Approximate Interval Betw Onset and D	ween
-	/Medical		Immediate Cause (Final disease or condition	E	ND.	STA	GE	GON	GESTIVE F CAP	5 HE	ART	!	URS	3.
	Examiner		resulting in death)	θ	Due t	o (or as a co	onsequence	of):	F	AILL	IRE		11-	
	be sit	lae		.AR	TEPT	0 SC	LEPO	TIC	- CAR	DIOVA	3CU4	12	40	ARS
	ificete be executed g physician end es the buriel-trensit	edical Examiner	Sequentially list conditions, if eny, leeding to immediate		Due to	o (or as a co	onsequence	of):		DISE	SASE		/	
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	the ell	ysic	Part II. Other significent cond	Itlons contributing to	o death but not	resulting in	the underlyin	g cause giv	en in Part I.	23b. <b>Did</b>	tobacco use co			
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Vital Records,	been should	Completed by Physician/M									an autopsy prmed?	avai	re autopsy fi labfe prior to apletion of ca eath?	0
~	The law ste hes page 2 :	E								10	Yes 2 No	1 🗆	Yes 2□	No
/ita		Be C	25. Was cese referred to medi examiner?					1.00	26. Plece of Deat	th (Check only o	one)			
of V	Physician: r this certific aral director,	၉	1 Yes 2 No			ER/Out		DOA Oth	4 Li Nursing Ho		dence 6 Oth			
ono	B \$ 5	tlon:	27. Manne of Death  1 Dineturel 5 Pen 2 Accident	/4	ete of Injury Month, Dey Year	28b. Ti	jury M	28c. Injur Wor	yat k? Yes 2 □ No	26d. Describe	now injury occur	180		
Division	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: Affer completely filled in by the fune	Certification:	3 Suicide 6 □ Cou	id not be 28e. Pl	lace of Injury - A		m, street, fac	tory, office		28f. Location (: City or To	Street and Numb wn, State)	er or Rurel	Route Numb	ber,
	Hospital 24 hours Funeral stely filled	edical	29a. Certifier 1 Certification (Check only one)	ying Physiclan: To al Examiner: On the	the best of my le basis of exam nanner steted.	knowledge, ination end	death occurr /or investigat	ed et the tir ion, in my o	ne, date and plece, pinion, death occur	end due to the red at the time,	cause(s) and ma date and place,	anner as sta	ted. the cause(s)	)
	within 2 To the comple	Mec	29b. Signature end title of cert		/	-		29c. Licens	e number		29d. Date signe			
	⊢ s ⊢ ő		1 C	and		W	1)	De	02556		03-	-21-	06	
		1	30. Neme and address of person	on who completed o	cause of deeth (	Item 23e) (1	Type, Print)	L			000	-179	mi	
2	3 45	1.1	31. Dete filed (Month, Day, Yes				100	, 0 -	1			218	51	
	Sta Registra		MAR 9		2. Redistrer's Si	griature #	door							

			1_ State	partment of Health and Mertificate of Death		0000	10:00
	g Q	17	Decedent's Name (First, Middle, Last)	Timeate of Death	2. Date of Death		3. Time of Death
	Physici /Medic		HAROLD LEEBUSSARD		MARCH 2	Day Year 2006	738 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral		Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Hagerstown    If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9 Rint	ngton  nplace (State or Foreign
	Director		214-48-4432 <sup>1™ 2□ F</sup> 59 Yrs.	Months Days Hours Min.	(Month, Day, Yes Sept. 17,	1946 Mai	yland
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	Mary -f sho	tor	Maryland Washington Clear S	Spring			1 ☐ Yes 2X No
	or 288	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?
	s 23a	erail	15709 Broadfording Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21722  Was Decedent of Hispanic Origin? (Spe	ocify Voe or No.	USA	ican Indian
36	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiter must be notified at once.	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Marned  1 □ Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto I	Rican, etc.)	Black, White	
21215-0036	72 hou	eted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	16b	. Kind of Business/I	
121	within ne.	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of work!! DO NOT use retired) Llder		commercia construct	
Q	Hygie Other ent, II	Be Co	17. Father's Name (First, Middle, Last)		(First, Middle, Maid		
/lan	uld be Wental Nrked	To B	Ralph Benjamin Bussard	Mildr	ed Louise	Bowers	
Maryland	l 2 sho and l			ling Address (Street and Number or Rura			
e,	1 and Health tem 2)		20a Method of Disposition 20b. Place of Disp			Dring, Mo	
ē	Pages nent of thant: If its ury or o			ematory or other place) wn Mem. Park 3/27/	06 Hag	gerstown,	Maryland
Baltimore,	permit. Departm Imports any inju		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	22. Name and Address of Facility 415 E.Wilson Blvd.,	MINNICH FU Hagersto		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between
ı	Physician			ULMONARY AF	REST		Onset and Death
	/Medical Examiner		Due to (or as a consequence of):	LEROTIC HEA	RT DI	SEASE	
$\geq$		ner	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):	, , ,		,	
	ecuted and -transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
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9	tificate ig phys as the	ledic	u.				
Вох	that the death certific ed by the attending p detached for use as	Physician/Medical		☐Ectopic pregnancy		23d. Date of deli	very Day Year
P.O. E	he dea the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)			<b>54</b> , 154.
	res that t signed by be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
ords	w require been sig should b	ted t	CHRONIC OBSTRUCTIVE LL	NG DISEASE	1 🗆 Yes	2 □ No 3 Pro	bably 4 Unknown
Sec.	2 2	Completed			24a. Was an autopsy performed	prior to d	topsy findings available ompletion of cause of
al	n: Th fficete or, pag		25. Was case referred to medical	26 Blace of Death	1 ☐ Yes 2 ☑		2□ No
<u> </u>	ysicia Is cert direct	To Be	examiner?  1 □ Yes 2 ☑ No Hospital: 1 □ Inpatient 2 ☑ ER/Outpatient	26. Place of Death ent 3 DOA Other: 4 Nursing Hor	me 5 Residence	6 Other (Spec	ufy)
o uo	Attending Physician: r death. sctor: Atter this certifice by the funeral director, I		27. Manney of Death 1 Polatural 5 Pending (Month, Day Year) 2 Accident Investigation		28d. Describe how in	njury occurred	
Division of Vital Records,	i or Atten after dea Director	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St		ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, dec 2 Medical Examiner: On the basis of examination and/or and manner stated.	ith occurred at the time, date and place, a nvestigation, in my opinion, death occurred.	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and tittiget certifier	29c. License number	29d.	Date signed (Monti	
			· MUVUI M.D.	D 61411	1		2006
ろム	-<		30. Name and address of person who completed cause of death (Item 23a) (Type MAHESH KRISHNAMOORTHY IIIIO MEDI-	e, Print) CAL CAMPUS RD STE		D 2174	
1 1	Sta Registi		31. Date filed (Month Pay Year) 4 2006 32. Registrar's Signature			٠٠١٠٠ ت	
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		_	For	• -		nd / Depa		of H	ealth a		fental Hyg	giene	) 6	10200
			Registrar  1. Decedent's Name (First, Middle, I	astl		001	incate	01 2	- Cutii		2. Date of Dea	Reg. No.		3. Time of Death
Ph	nysicia	an	Virginia Lucill								Month MARCH	Day	2006	10:45P.M.
	Medic				um harl		4b Ciby 1	Town or	Location of	of Death	MARCH		nty of Death	
E:	kamin	er	4a. Facility Name (If not institution, g Reeders Memoria		muerj			onsb		) Death			ashing	
				. Sex	7 Aco /In ure	last birthday)	If Under		If Under:	24 Hrs.	8 Date of Birt			
	neral		5. Social Security Number 6. 234-38-8191	1 M 2 X F	7. Age (III y/s.	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Aug. 18	y Year) 2 1018	West	pplace (State or Foreign intry) t Virginia
Dire	ector	-	Usual Residence of Decedent		0,						Aug. 10	3,1310	WES	L VIIgIIIIA
and	-		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
Aary	e Da	ō	Maryland Was	hington		Насе	rstow	m						1 ☐ Yes 2 🖾 No
the N	all or	Director	10e. Street and Number				10f. Zip					10g. Citizen	of What Cou	untry?
with g	2	ā	17530 Swann Roa	đ			10	217	40			USA		ŕ
ath	ters	rai			edent Ever in l	10 112 1	Man Daned			ain? (Sn	anifu Vas ar Na		Race - Amer	ican Indian
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.	action	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	Armed F 1 ☐ Yes If Yes, G	orces? 2 <b>X</b> No ive		was Deced If Yes, spec 1 \( \text{Yes} \) 2		n, Mexicar Specify:		ecify Yes or No- Rican, etc.)	1	Black, White	, etc.
Maryland 21215-0035 to 2 should be filed within 72 hours aff than Mental Hygiens 72 is marked other than "malited" or	4	d b		Year or I	Jates:	160 Dane	danda Hava	1.000.00	ntine.			16b. Kind o	f Business/l	nduetar
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Jed Vgie	1		12 17. Father's Name (First, Middle, La	0		asse	шотет		18 Mothe	ar's Nam	e (First, Middle,			ler
De fi	- N	Be	, , ,	31)							•	Wildricon Can	1411,07	
Nem Men	atic	ို	Oscar Rowzee								Fultz		-	. 0-43
and and	E E		19a. Informant's Name/Relationship				•	,			al Route Numbe			
and alth	er tr		James R. Bowen	- son							erstown			
Baltimore, bermit. Pages 1 ar Department of Hea	t t		20a. Method of Disposition	□ Bomoval from	20b.	Place of Dispo cemetery, crei	sition (Nam matory or ot	ne of ther plac	θ)		Date	20c. Location	on - City or 1	Fown, State
Pages	2		1 ☑ Burial 2 ☐ Cremation 3  `4 ☐ Donation 5 ☐ Other (Spe		State	alem C	hurch	Cem	etery	7 3	/23/06	Slanes	sville	, W. Va.
nit.	in in		21. Signature of Funeral Service Vice	ensee .	0 -	22	2. Name and	d Addres	s of Facili		NNICH FU			
D Ped	a da		-COM	(1) //	Kin									Land 21740
110			23a. Part1. Enter the disease, or co shock, or heart failure. List or	ompliations that	caused the dea	th. Do not ent	ter the mode	e of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate
100			shock, or heart failure. List or Immediate Cause (Final	nly ne cause on	each line.	/		1	15	Τ.:	dilan			Interval Between Onset and Death
Phys			disease or condition resulting in death)				UM	90	87/	ic	diseas			YEARS
Exan	dical		Tooland in dollar,		(or as a conse									YEARS
Exam			Sequentially list conditions,	b										TEARS
ъ	Ħ	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conse		- 1	1.1	2					DAYS
60, be executed	ysicien and ne burial-transit	an	that initiated events	c	vinary	/	inf	uv	21 ~					Driys
oʻ š	rial-	Ψ.	resulting in death) Last	Due to	(or as a conse	quence of):	/							DAYS.
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68 Tificat	been signed by the attending pry should be detached for use as the	Completed by Physician/Medi	IC CCLIAIC		6							T		
Box eath cert	esn.	J.	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		∃Ectopic pr	egnancy					Date of deli	•
deat u	d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at time of		Other (sp						Month	Day Year
P.O.	ache	hys	9 🗆 Unknown	9□ Unk	nown									
T ta	det	y P	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	inderlying ca	ause giv	en in Part I		23e. Did t	obacco use c	contribute to	the cause of death?
	ng p	d D	Hyportensis	~							1 🗆 '	Yes 2□N	o 3□Pro	obably 4 Hinknown
O Pe	nous	ete	O'Cordi m	IXhaTL	11						24a. Was	an 24	th Were au	topsy findings available
e av	9 2	dш	v will in	1 opran	9						autor		prior to death?	completion of cause of
	pag	Ö		1							1 ☐ Yes	212 No	1 🗆 Yes	2 <b>9</b> No
Division of Vital Records, P.O. Box 687 to a vertificate of Attending Physician: The taw requires that the death certificate after death.	lo the Funerell brector: Affer fins certificate has completely filled in by the funeral director, page 2	Be	25. Was case referred to medical examiner?	He anitate				OH-	05	/	th (Check only o			
hysi	die	ပ္	1 ☐ Yes 2 No			ER/Outpatie			4000	ursing H	ome 5 Resi			cify)
0 5	nera		27. Manner of Death  ✓ Natural 5 ☐ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o	of 2	8c. Injun Worl	y at k?		28d. Describe	how injury oc	curred	
ath.	5 e 5 t	atic	2 ☐ Accident investiga				М	1 🗆	Yes 2	No				
VIS Atte	by t	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Plac	ce of Injury - At ding, etc. (Spec	home, farm, st	reet, factory	, office			28f. Location (City or Tox		umber or Ru	ral Route Number,
ia affe	d in	eri	4 [] Normords	Dali	aling, oto. (opoo							,		
Hospitel of the American	rille / fille		29a. Certifier Certifying	Physician: To the	ne best of my kr	nowledge, deat	th occurred	at the tin	ne, date ar	nd place	, and due to the	cause(s) and	manner as	stated.
9 Ho	etel)	ledical	(Check only 2 Medical Ex	kaminer: On the and ma	basis of examir nner stated.	nation and/or in	vestigation,	, in my o	pinion, dea	ath occur	rred at the time,	date and pla	ce, and due	to the cause(s)
To the within 2	omp	₹ e	29b. Signature and till of certifier				290	. Licens	e number			29d. Date sig	gned (Monti	h, Day, Year)
<b>⊢</b> 31	- 0		1	720/06			2	000	622	23		3/20	102	
			3			- 00-1 (7			0 - 0			1-5	- 10	
60-1			30. Name and address of person w			em 23a) (Type,	, Print) ACEDO	TOUN	МΛГ	ονι Δι	ND 21740	30.	1-739-	-7100
5H-6			DR. PRAVEEN BO 31. Date filed (Month, Day, Year)	LARUM 34	O MILL		HUEKS	LOMIN	, MAI	VI LA	10 61/40	, 50.	_ , 0,5	
	Sta		31. Date filed (Month, Day, Year)	2000 32.	Registrar's Sigi		1							
	Regist	al	FIMIL & E.	2000	distant	13. 19	with							
DHMH 17	Rev 1/2	001		-		0010111								
						ORIGINA	AL							

NAME: BOWEN, VIRGINIA L.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie ( 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Abraham , Block March 16, 2006 22:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
July 25, 1933 9. Birthplace (State or Foreign Country) New York, N.Y. 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1**⋈** M 2□ F Months Days 127-24-3394 72 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or iteme 23a or 28a-f ehow eny injury or other traumatic event, I'm Medical Examinations in must be notified at once. 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Chevy Chase 1 TYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2624 Spencer Road 20815 United States Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 □ Widowed 4 ₺ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 1-4 Elementary/Secondary (0-12) Chemist Federal Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Max Block Esther Weinstein 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Gordon -daughter 2624 Spencer Road Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1X Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State King David Memorial Gardens 3/19/2006 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Bor wardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examine requires that the death certificate be executed attending physicien and for use as the burial-transit Multiple Sclerosis Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No within 24 hours efter death.

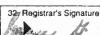
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) D0062520

Division of Vital Records, P.O. Box 68760,

Name and address of person who completed cause of decident (Item 23a) (Type, Print)
Maria D'Arbella, M.D. 1500 Forest Glen Road Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) MAR 2 0 State Registrar

2006





MID

March 18, 2006

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			1 - For State Registrar	State of Maryland	/ Depa		of He	ealth an		ental Hy		0.6	10202
	Physici	an	Decedent's Name (First, Middle, Last)	PROIDI *						2. Date of Dea Month March		2006	3. Time of Death
	/Medic	cal	DOROTHY MAY KNILL  4a. Facility Name (If not institution, give s			45 City T	our and	anation of F		March	17,		3:17 AM
	Examin	er		rive		Fred		ocation of [	Death			ederic	
	Funeral	7	Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1	Year	If Under 24	Hrs. 8	. Date of Birt	h	O Dieth	place (State or Foreign
	Director		220-05-6919 1 Usual Residence of Decedent	IM 2対F 84	Yrs.	Months	Days	Hours	Min.	Nov. 2	9,192	1 Mar	yland
	iryian ihow	_	10a. State 10b. County	10c. City, T									10d. Inside City Limits
	8a-f s	cto	Maryland Frederick	Fre	deri	ck							1 TyYes 2 No
	permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelih and Mentali Hydione.  Department of Heelih and Mentali Hydione.  any Injury or other traumatic avent, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 868 Waterford Driv	re		10f. Zip 0	02-4	088				of What Cou ed Sta	
	e me	Iner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decede	nt of His	panic Origin Mexican F	n? (Speci	fy Yes or No- can, etc.)		Race - Ameri Black, White,	can Indian,
9	s efte	by FL	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 🏝 Divorced	1 □Yes 2t No If Yes, Give		1□ Yes 2l		Specify:		ou.,, o.o.,		pecify:	816.
3-003p	houn turat'	ed b	15. Decedent's Educ	Year or Dates:		dent's Usual		ion		1		Whi	
<u>.</u>	iin 72 n "na nedic	Completed	(Specify only highest grade	completed)	(Give	kind of work DO NOT use	done du	ring most o	of working			of Business/Ir comery	
7	d with	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	(	Clerk					Dept.	of As	sessments
<u> </u>	e file ai Hyg I othe	BeC	17. Father's Name (First, Middle, Last)				- 1			First, Middle,	Maiden Su	mame)	
ylallu	ouid b Ment harked hatic a	To	George Dewey Knill	_						Reid			
Mar	ind 2 sh eith and 27 is m or traum		19a. Informant's Name/Relationship (Type Edward T. Brown, Jr								-	own, State, Zij ind 208	
ballimore,	E E E E		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Place	of Dispo	sition (Name	e of ner place)	Ма	rch Dat	21.	20c. Loca	tion - City or To	own, State
Ě	ury England		'4 □Donation 5 □Other (Specify)	Memo	arkia rial	awn Park		į	2006		Rockv	ille,	Maryland
מַ	ermit. Pepert nport ny Inj DCS.		21. Signature of Funeral Service Lionse		22					1 Fune	ral H	ome, 1	0 East
4	405 # G		MANDO	¥100689								, Mary	land 20877
1	nysician		23a. Part 1 Effective disease, or complices of the art allure. List only on Immediate cause (Final disease or condition resulting in death)	e cause on each line.  Myocardial Iso	chemi	er the mode La	of dying,	such as ca	ırdiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death Hours
	/Medical Examiner			Due to (or as a consequence Metastatic Para		atic C	arci	noma					Months
	nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence	ce of):								
,00,	oe execucien end cien end suriai-tra	il Exar	that initiated events resulting in death) Last	Due to (or as a consequence	ce of):								
0	physic physic the b	edicai	d										
٥ ٢	certifi Iding	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy							220	. Date of delive	25.
<u>.</u>	res thet the deeth certificate be executed igned by the ettending physicien end be detached for use as the buriai-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic prec Other (spec	gnancy crfy)				230	Month	Day Year
_	met ti ed by detac		Part II. Other significant conditions con	tributing to death but not resulting	g in the ur	nderlying cau	use given	in Part I.		23e. Did to	bacco use	contribute to the	he cause of death?
60.00	quires n sign uid be	ed by	Cachexia							1 □ Y	es 2K	lo 3 ☐ Prot	oably 4 Unknown
2	s been si	piete								24a. Was a		4b. Were auto	ppsy findings available
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	artifice ctor. I	Be	25. Was case referred to medical examiner?				2	26. Place of	f Death (C	Check only or			22110
> i	iding Physician: th. After this certifics funeral director, p	ို	1 ☐ Yes 2 🛣 No		Outpatien			4   Nursir				Other (Specif	(y)
	After After Tunera	on:	27. Manner of Death 1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28t	o. Time of Injury		c. Injury a Work?			d. Describe h	ow injury o	ccurred	
	Attender death rector:	Icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home,	farm etre	M factory		s 2 No		Location /S	troot and N	umber or Rum	al Route Number.
<u>}</u>	rs efter el Dire ed in by	Certification:	4 Homicide determined	building, etc. (Specify)	taili, sile	ser, ractory, r	omo		201	City or Tow		dilipol of Hore	i novie reimber,
;	I of the horseled retaining Physician: The law requires their begein certificate be executed. Within 24 house for the statement of the Punerel Director; After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  1	ician: To the best of my knowled er: On the basis of examination and manner stated:	lge, death and/or inv	occurred at restigation, in	the time, n my opin	, date and p nion, death o	place, and occurred	d due to the c at the time, c	ause(s) an late and pla	d manner as s ace, and due to	tated. o the cause(s)
1	Comp.	ž	29b. Signature and title of certifier	· VA			License r					igned (Month,	
1	>		A.Z.HEGAT	I'MD W.			D441	64		M	arch	17, 20	06
-			30. Name and address of person who cor	,		,							
	-01		A.Z. Hegazi, MD, 4	32 Spaistrar's Signature			e, F	reder	ick,	Mary1	and 2	1702	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 20 20	06 Secret &		seles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per:H1, 3/29/06, DES MCCo. State of Maryland / Department of Health and Mental Hygiene 1- State MEND16a, and 16b, per FH, and 23a Certificate of Death Reg. No. 3/29/06, DPS, MoCo 2 Date of Death 3. Time of Death Year **Physician** BURNS HOMAS 11:15A MAR 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Montgomery Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 87 Director Yrs 1918 Albion, 106.16.5665 1, N.Y. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1**X**]Yes 2 ☐ No **Funeral Director** Maryland Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12520 Two Farm Drive 20904 U.S.A. 12. Was Decedent Ever in U.S. 42 Armed Forces? 1 Mg Yes 2 D No 1f Yes, Give Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1945 to Maryland 21215-0036 1 Tes 2 No Specify Specify: White Be Completed by 3 ₩Widowed 4 Divorced the Medical Exa 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry National SecurityAgency College (1-4or 5+) 5+ Years Elementary/Secondary (0-12) Cryptologist U.S. Government **Analyst** . Peges 1 end 2 should be filed v tment of Health and Mental Hygie fant: if itam 27 is marked other t jury or other traumatic avant, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Edward Burns Kathryn Ambrosia Clark ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan B. Strand/Daughter 2826 Woodlawn Avenue, Falls Church, Virginia 22042 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Peges 1
Department of H
important: if its
any injury or ot
once. 03/18/ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 2006 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, 21. Signature of Funeral Service Licen-INC. 11800 New Hampshire Avenue, Silver Spring 20 904 Non: Approximate Interval Between Onset and Death WEE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Immediate Cause (Final MULTIPLE **Physician** Pneumonitis 6 MONTAS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Multiple Myeloma 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and the burial-transit The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Be Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy performed? res 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: the funeral director, 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident after death 6 ☐ Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ፩ 4 Homicide filled in I To the Hospital of within 24 hours at To the Funersi C completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MAR 16, 2006 D0061083 ranu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CONTER DR. #300, ROCKVILLE, MD 20850

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 20

2006

Momas

32 Registrar's Signature

State Registrar

10

egistrar's Signature

OCME

March 16, 2006

111 Penn Street, Baltimore, Maryland 21201

authall, MO

southall, MD

tamela E.

31. Date filed (Month, Day, MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of N	Naryland / Depa Ce	artment of H			giene 0 6	10205
			Decedent's Name (First, Middle,	Last)				2. Date of Dea Month		3. Time of Death
	Physicia		John Harol	d Bauer	3 x			March	17 200	/ • ( ) ( ) A M
	/Medic Examin		4a. Facility Name (If not institution,		or)	4b. City, Town, o	r Location of Death		4c. County of	Death
	LAGITHI	ÇĹ	Wilson Health			Gaith	ersburg		Montg	gomery
	Funeral		5. Social Security Number		Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		. Birthplace (State or Foreign Country)
	Director		256-34-0980	1 X M 2 □ F	98 Yrs.	Months	Hours Will.	April	23,1907	Massachusetts
	D		Usual Residence of Decedent							404 Inside City Limite
	rylar	L	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	Ba-f.	cto	MD Montgo	omery		Gaithersb	urg			
	or 21	Director	10e. Street and Number 301 Russell Ave	mus #216		10f. Zip Code	20077		10g. Citizen of Wha	ŕ
	72 hours after death with the Maryland 'naturel', or Hems 23a or 28a-f show dieal Examinat must be ricillical at	La L					20877	4.44	United S	
	tems	une	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Hace - Black,	American Indian, White, etc.
36	s afte	by Funeral	1 ☐ Never Married 2 X Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	_No	1 ☐ Yes 2 🗓 No	Specify:		Specify:	White
8	hour		15. Decedent's	Year or Date	******	dent's Usual Occup	ation		16b. Kind of Busin	ness/Industry
7	n 72	Completed	(Specify only highest	grade completed)	(Give	kind of work done DO NOT use retired	during most of wor	king	TOD. TAING OF BOOK	nosa magany
12	withi ene. than	duc	Elementary/Secondary (0-12)	College (1-4d	or 5+)	civil Eng:	ineer		Engineer	rino
2	Hygi Hygi ther		17. Father's Name (First, Middle, L	ast)				ne (First, Middle,	Maiden Sumame)	
an	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importents: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show among young to other traumatic event, the Medical Examinar must be inclined all once.	To Be	John C. Bauer				Marga	ret Mart	in	
<u></u>	mark mati	ř	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ng Address (Street				ate, Zip Code)
<b>S</b>	id 2 s Ith ar 27 is trau		John M. Bauer/		944 E	eatherst	one Stree	t, Gaith	nersburg,	MD 20878
é,	1 ar Hea Rem 2		20a. Method of Disposition		20b. Place of Disp	nsition (Name of		Date	20c. Location - Ci	
<u></u>	Se in a se in		1 XBurial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp		de Gate OF F	leaven	Marc	h 21 006	Silver S	pring, MD
Baltimore, Maryland 21215-0036	it. Partme		21. Signature of Funeral Service L		2	2. Name and Addre				ne, 10 East
Ba	Department of the population o		12 N. A. V.	1:120 7		Deer Parl	k Drive,	Gaithers	sburg, MD	20877
	- 12/		23a. Part1. Enter the disease, or o	complications that cause	sed the death. Do not en	ter the mode of dyir	ng, such as cardiad	or respiratory ar	rest,	Approximate
			shock, or heart failure. List of immediate Cause (Final	only one cause on each	n line.					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	Dementia					
	Examiner			Due to (or	as a consequence of):					
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):					
	ted nsit	Ë	Cause, Enter Underlying							
	be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
8760,	The law requires that the death certificate be executed to be associated as been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E								
687	ficate I physics the b	odic		0.						
	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	of delivery
Вох	eath atter	clar	in the past 12 months?			□Ectopic pregn <i>a</i> nc □ Other (s <i>pecify</i> ) _	У		Month	h Day Year
O.	at the de by the	ıysi	9 Unknown	9□ Unknow	n					
σ.	that led b	y P	Part II. Other significant condition	ns contributing to deat	h but not resulting in the	underlying cause gr	ven in Part I.	23e. Did to	obacco use contrib	ute to the cause of death?
ds,	uires sign ld be	d by						101	res 2□No 3	Probably 4 XUnknown
Vital Record	w requ been shoul	Completed						24a. Was	an 24b. We	ere autopsy findings available
Re	The law cate has page 2	Ę.						autop perfo	rmed? dea	or to completion of cause of ath?
a			OS Was asserted to madical				OG Diseas of Do	1 ☐ Yes ath (Check only o		Yes 2 No
₹		Be	25. Was case referred to medical examiner?	Hospital:	ations 20 EB/Outpatie	ott			dence 6 Other	(Specify)
of		. To	1 ☐ Yes 2 📉 No 27. Manner of Death	1 ☐ Inp					now injury occurred	
	ding l h. After funer	tion	1 XNatural 5 ☐ Pending		Day Year) Injury	of 28c. Inju Wo M 1	rk? ]Yes 2.⊟No			
S	or Attendil after death. Director: A in by the fu	ica	3 Suicide 6 Could n	not be 290 Place of	Injury - At home, farm, s	treet, factory, office		28f. Location (S	Street and Number	or Rural Route Number,
Division	after Dire	Certification;	4 Homicide determine	building	, etc. (Specify)			City or Tov	vn, State)	
_	Hospitel 24 hours a Funerel t stely filled		29a. Certifier 1 X Certifyin	g Physician: To the be	est of my knowledge, dea	ith occurred at the ti	me, date and place	and due to the	cause(s) and manr	ner as stated.
	24 h	Medicai	(Check only 2 Medical I	Examiner: On the bas	is of examination and/or i	nvestigation, in my	opinion, death occi	irred at the time,	date and place, an	d due to the cause(s)
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (	(Month, Day, Year)
	041		> /\ A	111.	16-	מת	20148		March 1	7 2006
,	* ~		30. Name and address of person	who completed cause	of death (Item 23a) (Type				naich I	7, 2000
			Steven Dolinsky				ithersbu	rg, MD 2	0877	
	Q+	ate	31. Date filed (Month, Day, Year)	2040	interests Cinn at the			0, 2		
	Regist		MAR 2 0	2006	Signature Signature	acted				
				N. contraga						

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State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** Cottrill 06 02:30 2 Dale Vernon March صل2 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth ellegan 728 Baker Street If Under 1 Year If Under 24 Hrs. Birth place (State or Foreign Country) 1947 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Aug 22, "KVII" 1√M 2□F Yrs. 217-42-7134 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County il Hygiene other then "naturel", or Itams 23a or 28a-f shov vent, Ita Medical Examiner must be notified at MD Cumberland Allegany 1x Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 728 Baker Street death v Funerai 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1965-71 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: white <u>م</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) MD State Highway laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked oth eny lightly or other traumatic event 2008. Be Pearl Cottrill William Cottrill, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 728 Baker Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) 728 Baker Street wife Chris Cottrill 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 3/29/2006 MD Rocky Gap Veterans Cemetery Flintstone 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices <sup>22. Nams</sup> and Address of Facility all Home, PA W 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death ant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, focil, or heart failure. List only one cause on each line. Immediate Cause (Final 5 YEARS **Physician** disease or condition resulting in death) CARDIOMYOPATHY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan page 2 2 No 1□ Yes To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medicai Certification: Division 1 S Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death Director: the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 | Homicide within 24 hours e To the Funeral I completely filled 150 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) å, 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2812006 March D36766

State Registrar 31. Date filed (Month Day) 2008

IKRAMADITYA POONAI, M.D. 32 Registrar's Signature 1000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CUMBERLAND, MD 21502

# with the Maryland deeth 1 filed within 72 hours after of Hygiene. "natural" Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. Int: If itam 27 Ia marked other than '

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the death certificate be executed the attending physician and been signed certificate has Attanding Physician: this After

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 120 Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<u>006</u> Year **Physician** 19 8:30 A MARCH PATSY MAE CLARK /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK THURMONT 15727-B SMITH ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 🛣 F 215-36-6218 1939 MARYLAND Director MARCH 1, 67 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ral', or items 23a or 28a-f show Examinar nutsi be notified at 1 ☐ Yes 21 No Directo MARYLAND THURMONT FREDERICK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15727-B SMITH ROAD 21788 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be RUSSELL RICHARDSON MOATS DOROTHY MARIE TRUMPOWER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15727-B SMITH ROAD, THURMONT, MARYLAND HAROLD C. CLARK/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 □ Donation 5 ☐ Other (Specify) 03/23/2006 LOCUST GROVE, MARYLAND ZION CEMETERY 22. Name and Address of Facility 21. Signature of 7606 Old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 rt1. Enter the disea Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. one cause on each line Immediate Cause (Final disease or condition resulting in death) to (or as a managuence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the burial-tran Due to (o as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnan in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Onknown Completed 290. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy perform 2 No the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manne 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 0 within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical completely (Check only one) 29b. Signature and title of certifie who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person OU OH-7 31. Date filed (Month 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

# Phillip Crockett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legibl		Please Type or Print in	Black Indelible Ink.	<b>Ensure All Copies</b>	Are Legible
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			For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H			giene Reg. No.	10000
	Physici /Medio	cal	Decedent's Name (First, Middle, La. PHILLIP WAYNE	CROCKETT				2. Date of De Month Mar	Day 13 20	3. Time of Death 06 4:45 PM
	Examir Funeral	ner	4a. Fecility Name (If not institution, giv  Genesis Health  5. Social Security Number  6. S	nCare - T	he Pines	If Under 1 Year	ston If Under 24 Hrs			albot  9. Birthplace (State or Foreign
	Director		218-34-2916  Usual Residence of Decedent  10a. State 10b. County	<b>X</b> M 2□F 67	Yrs.  10c. City, Town or Lo	Months Days	Hours Min	APRIL	11,1938	MARYLAND  10d. Inside City Limits
	r 28a-f sho	Director	MD TAL	вот	EASTO				10g. Citizen of W	1 ☐ Yes 2 🛣 No
	death with ns 23a or reast be	Funeral Di	12 BAKER STREE	12. Was Decedent	Ever in U.S. 13.1	Was Decedent of H	601	Specify Yes or No	USA 14. Race	- American Indian,
-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinat raist be notified at	b	1 Never Married 2 Married 3 Widowed 4 Divorced		1957-1963	If Yes, specify Cuba	Specify:		Specify:	MITTE
21215-0036	filed within 72 Hygiene. other than "ne ent, the Media	Completed	(Specify only highest grant (0-12)	College (1-4or 5	(Give	kind of work done of DO NOT use retired	during most of we ) AGER		COMMUNI	CATIONS
Maryland	should be filtend Mental Hy marked oth	To Be	17. Father's Name (First, Middle, Last, BURTON CROCKETT					me (First, Middle, L BETTS	Maiden Sumame	)
	1 and 2 sho Health and tem 27 is my		19a. Informant's Name/Relationship ( BRENDA J. CROCK		12 B	AKER STR		TON, MD		State, Zip Code)
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)	y)	20b. Place of Dispo cemetery, cren WOODLAWN	natory or other place		Date -17-2006	EASTON	City or Town, State
Ball	permit. Depart Import any inj		21. Signable of Funeral Service Licen	Helkenh	een 40	S C T.TRI	LFENBEIN FRTY ST	CENTRE	VILLE. M	
	Pnysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one gause on each lin a.	the death. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory a	rest,	Approximate Interval Between Onset and Death
8760,	Examine be executed whysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of): a consequence of):					
P.O. Box 6	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	]Ectopic pregnancy ] Other (specify)			23d. Date Mon	of delivery th Day Year
	w requires that the d been signed by the should be detached	ed by Pr	Part II. Other significant conditions of Africa Sciences  My pertensis		ut not resulting in the u	nderlying cause give	en in Part I.			bute to the cause of death?
Il Records,		Completed by	Mypertension	71				24a. Was autop perio 1 □ Yes	rmed? pr	ere autopsy findings available for to completion of cause of eath?
ion of Vital	× U	ation; To Be	27. Manner of Death Natural 5 Pending 2 Accident investigation		ry 28b. Time of	28c. Injun Worl	or: 42 Nursing	eath (Check only of Home 5 Residence 128d. Describe 1		,
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director; After th completely filled in by the funeral	Medical Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injuding, et	ury - At home, farm, str c. (Specify)	eet, factory, office		28f. Location (\$ City or Tox	Street and Number vn, State)	r or Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely filled in	edicai	29a. Certifier (Check only one)  Certifying Principle (Check only one)	nysicien: To the best niner: On the basis of and manner sta	of my knowledge, death f examination and/or in- ated.	n occurred at the tim vestigation, in my of	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To T Com	W	29b. Signature and title of certifier	Mil	Key	29c. License	number 77	3-4	29d. Date signed	(Month, Day, Year) 14:06
				DLLY MD	CIO?	DUTCHM	an's h	ANE 1	CASTON	MD 21601
	Sta Regista		31. Date filed (Month, Day, Year)		aris Signature	Soul !				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrer #26, per/physician, 3/21/06, Certificate of Death WCHTRag. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 17 2006 5:30AM MARTHA WHITE DUNCAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 23961 LYNNEWOOD DRIVE ST. MICHAELS TALBOT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/01/1914 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 💆 F 91 Yrs. Director Virginia 219-36-7404 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD Talbot St. Michaels Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23e 23961 Lynnewood Drive 21663 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 Yes 2 No Specify: Specify ð 3 Widowed 4 □ Divorced Year or Dates: white "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 72 th and Mental Hygiene. 7 is marked other then "no Elementary/Secondary (0-12) College (1-4or 5+) Educator Public Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas R. White Elsie R. Mason 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If Item 27 is n eny injury or other treum once. W. Wilson Duncan, Jr. (son) 23961 Lynnewood Dr., St. Michaels, MD 21663 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) First Baptist Cemetery 3/22/2006 Pocomoke City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

103 Linden Ave., Pocomoke City, MD 21851
Approximately 104 Approximately 105 App Mu Approximate Interval Between Onset and Death Immediate Cause (Final CholANGITIS Physician 30/04/ disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, bissase or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician Box 68760. Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9□ Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 - No 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence Alexine (Specify) RESIDENCE Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death. investigation М 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only one) and manner stated. within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

E.T. 3

State Registrar

Ludwig J. Eglseder 31. Date filed (Month, Day, Year)

MAR 2 1 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wh

III, M.D. - 503 Cynwood Dr., Easton, MD 21601 32. Reistrar's Signature

SAL

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			For State Registrar	State	of Maryland		artment of H tificate of I		d Mental Hygi	iene) () () og. No.	10210
3	Physici /Medic		1. Decedent's Name (First, Mid Darwin		rewyer	Jr.			2. Date of Death Month March 1		3. Time of Death 9:12A M
	Examin		4a. Facility Name (If not institut Shady Grove	Adventist	: Hospital		4b. City, Town, or Rockv			4c. County of De	ery
~	Funeral Director		5. Social Security Number  218-16-0346  Usual Residence of Decedent	6. Sex 1 X M 2 □ F	7. Age (In yrs. la 80	Yrs.	Months Days	Hours M		,1925 M	irthplace (State or Foreign Quintry) Innesota
	Maryland -f ehow	tor	10a. State, 10b. Coun North Carolina Dat	*	10c. City,	Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	h with the	al Director	10e. Street and Number 901 Caffey	Court			10f. Zip Code	27949		og. Citizen of What C ted State	country? s of America
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Mudical Exeminat must be notified at	Completed by Funeral	11. Marital Status  1 Never Married 2 M M 3 Widowed 4 Divorce	12. Was De Armed	ecedent Ever in U.S Forces? s 2 No Give Dates: 1943-4		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🛣 No	ispanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Black, Wh	nencan Indian, lite, etc. White
21215-0036	within 72 ho ene. then "natur the wedical	ompieted		ent's Education hest grade complete 2) College 5+	d) a (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Dentist	during most of v	working	16b. Kind of Busines  Dental	
	uld be filed within fental Hygiene. rked other than '	To Be Co	17. Father's Name (First, Middle Darwin R. D	le, Last)	r.				Name (First, Middle, A dys Nergor		
, Maryland	Health and Notes to the stand of the stand of the standard of		19a. Informant's Name/Relation Phyllis Drewy						Rural Route Number, uck, NC 27		, Zip Code)
Baltimore,	permit. Pages 1 a Department of He Important: If Item any njury or oth		20a. Mathod of Disposition 1		m State Ce	metery, crer k1awn	sition (Name of natory or other place Mem. Par	k 03	/21/06		e, Maryland
Balt	permit. Departi Import any inj		21. Signature of Funeral Servin	ce Licensee		1	Name and Addre	ss of Facility H Hampshi	ines Rinal re Ave, Si	ilver Spri	ing, MD 20904
8760,	Physician /Medical buysician and physician and physician and silve bruial-transit	dical Examiner	23a. Part Fifter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due  c	to (or as a consequence to (or a consequence	ence of):	Myoc my 6	nfin 2 te	Disa	rnetron SIP	Interval Between Onget and Death, Onget and Death, Onget and Death, Onget and Death, Onget and O
.O. Box 6	death certifi e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	1 Liv	outcome of pregnar e birth 2  Fetal egnant at time of de known	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
<u>α</u>	sign d be	by	Part II. Dther significant cond	litions contributing to	death but not resu	Iting in the u	nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 Dunknown
Vital Records,		Completed							24a. Was a autops perform 1 \( \text{Yes} \) 2	y prior t	autopsy findings available o completion of cause of ? es 2 \sum No
VIII.	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medi examiner?	Hospital	□Inpatient 2	R/Outpatier	nt 3□ DOA Oth	or:	Death <i>(Check only on</i> g Home 5 ☐ Reside		pecify)
n of	fter	ion: T	27. Manner of Death 1 ☐Natural 5 ☐ Pen	28a. Da		28u. Time o Injury	Wor		28d. Describe ho	ow injury occurred	
Division	or Atten fiter deat Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Cou	estigation uld not be armined 28e. Pla bu	ace of Injury - At hor ulding, etc. (Specify,	me, farm, str		Yes 2 □No	28f. Location (St City or Town		Rural Route Number,
	ne Hospital n 24 hours a ne Funeral C	ledical C		cal Examiner: On the					ace, and due to the ca		
)	To the within 2 To the complete	×	29b. Signature and title-of cert		ode,/	4/	29c. Licens	33	26/ 1	9d. Date signed (Mo	15, 2006
	17.		30. Name and address of pers William Doole	av MD	9900 Med	ical C	enter Dr	ive. Ro	ckville, M	D 20850	
	Sta Regist		31. Date filed (Month, Day, Ye	2 0 2008	. Registrar's Signat	US A	parle				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Eileen Reynolds 2:00 AM M Doane March 16, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M XXXF 88 Director 318-10-0447 Yrs May 10, 1917 Escanaba, MI Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at Director 1X Yes 2 □ No Montgomery Maryland Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Иете 23a 3507 Saul Road 20895 Pages 1 end 2 should be filed within 72 hours after death Funeral U.S.A 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 ŏ Completed by 1 ☐ Yes 2 No Specify: Specify: White 3∑ Widowed 4 Divorced "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 2 Years Own Home other t Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental is marked Edward P. Reynolds Lillian Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a JOhn R. Doane / Son 16120 Willow Lane Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 To Cremation 3 ☐ Removal from State Depertment of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) March 22,06 Falls Church, Va. National Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Joseph Gawler's Sons, INC. 5130 Wisconsin Ave. N.W. Wash. D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cevebra **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 DNo 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death ed by the e 5 Other (specify) 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. phillatan 2 (XNo 3 Probably 4 Unknown 1 ☐ Yes peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe certificate 1□ Yes 210 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Unpatient မှ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. i Director; A id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 \( \text{Homicide} (Excertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the ! and manner stated 29b. Signature A 29d. Date signed (Month, Day, Year) 02949 10 cause of death (Item 23a) (Type, Print) MD VITAN 8600 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 20 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DI DUCA PAIIT. 17, 2006 March 8:41 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Shady Grove Adventist Hospital 8. Date of Birth (Month, Day, Year)
Sept. 9, 1943 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1∑M 2□F 62 Yrs. Director 219-43-6270 England Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or iteme 23a or 28e-f ehow The Medical Examinar must be notified at 1 Yes 27 No Md. Montgomery Germantown Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 97 Steeple Court 20874 United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 

Widowed 4 

□ Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Engineer other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill thent of Health and Mental H tant: if item 27 is marked of Be Ben Di Duca Armenia Fecinni 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar important: if item 27 is any injury or other treu-44 Mill Street Russell Ontario, Canada K4R1El Karyn Villeneuve (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 25, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hope Cemetery Ottawa, Canada 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home wells 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a. mles Moni Pnysician 6517 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical use as the attending p 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours e To the Funeral I completely filled To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 059929 03-17-06 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Aaron Snyder M.D. 9701 Medical Center Dr. Rockville, Md. 20850 31. Date filed (Nonth Day Year) 32. Registrar's Signature State 2006 Registrar

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NK		For State Registrar	State of Maryla		ficate of D		-	og. No: 006	10213
		1. Decedent's Name (First, Middle, Las	st)				2. Date of Deat		3. Time of Death
Physic		Ethan Roder	er Embree				Month March	Day Year 1 25, 2006	4:58 P
/Medi Exami		4a. Facility Name (If not institution, give		4	b. City, Town, or Li	ocation of Death	1141 (2)	4c. County of Dea	ith
		36 Cattail Lane			E1kton			Cecil	
Funeral		5. Social Security Number 6. Sec		,	If Under 1 Year		8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreig ountry)
Director		202-72-8735	OM 20 F 15	Yrs.		\$	eptemb	er 23,19	990 PA
and		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Loca	tion				10d. Inside City Limits
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If tem 27 is marked other then "natural, or its may highly or other traumatic event, the Medical Example page.	उ	10 17. Father's Name (First, Middle, Last)	_	Stud		8. Mother's Name	(First Middle A	Maiden Sumamel	
ancal the first of	Be	John H. En						·	
aryla should ind Men marke	2	19a. Informant's Name/Relationship (7		19h Mailing		Peggy J		City or Town, State,	Zin Code)
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Heali		Peggy R. Embree		. Place of Disposit	on (Name of	D		20c. Location - City o	
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		23a. Part1. Enter the disease, or composition, or heart failure. List only	plications that ceused the de	ath. Do not enter	me motte of dying,	such as Sardiac or	respiratory and	<u>n</u> , MD 2	1 92 preximate
	H	shock, or fleart failure. List only Immediate Cause (Final	one cause on each line.		01 - 1-1	h D			Interval Between Onset and Death
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OX th cer rendiir	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe		ctopic pregnancy			23d. Date of de	
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or At fler d	E	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	t home, farm, stree	t, factory, office	2	City or Town	reet and Number or F n. State) 36 Cat	tail Lane
Division of Vital Records, P.O. Box 68760, — To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit.		00.0.7		Kiver		d-4	Elictor	IMD	
Hoss 24 hor Fune Fune	Medical		nysician: To the best of my k						
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•		- Carack	rallaur	19		.M.E		March 26	, 2006
1		30. Name and address of person who	completed cause of death (It	tem 23a) (Type, Pi		n Ctroot	Do1+4~	010 M1	and 21201
		31. Date filed (Month Day, Year)	32. Registrar's Sig	nature		m street	ратстп	ore, Maryl	Land ZizUi
Si	tate	31. Date filed (Month, Day, Year)	006	H has	all 3				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 17°ay 2006° Elliott Mark Endelman 4:20A. /Medical 4a. Facility Name (If not institution, give street and number)
Casey House 4c, County of Death Montgomery 4b. City, Town, or Location of Death RockVille Examiner If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August2, 1944 Birthplace (State or Foreign Country) **Funeral** 056-34-6370 1**X** M 2□F Brooklyn, N.Y. 61 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Worle permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any lury or other traumatic event, the Madical Examinant must be notified at once. Maryland Montgomery Wheaton 1 Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20902 2116 Henderson Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Management Consultant Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Endelman Cohen Anne Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2116 Henderson Avenue Wheaton, Maryland 20902 William Ryder -Executor 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rockland Cemetery 3/18/2006 Sparkill, New York 4 Donation 5 Other (Specify) 21. Signature of Fune al Service Licensee Donald Voor Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 the 23a. Part to mer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed c. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown cate hes been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No certificate funerel director. 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Xother (Specify) Hospice Certification; To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert Injury 1 Natural s after dea. 5 Pending 1 Tes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature a nd title ol dertifie 29c. License number D35635 March 17, 2006 WU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855 31. Date filed (Month, Day, Year) MAR 2 0 32 Registrar's Signature State 2006 Registrar

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	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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icate be executed	Chysician be executed by the private and branch but at the private and the pri	edicai Examiner	shock, or headfailure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  List only one cause on each line.  Initiated FAI LURG-  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury			М	28c. Injury at Work? 28d. Des				cribe how injury occurred		
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			For State Registrar	State of Marylan	d / Departme	ent of Health and	Mental Hygie	ne nn 6	10216		
		_	The State of Death Reg. No.: Certificate of Death Reg. No.: 2. Date of Death 3. Time of Dea								
r	Physici	an	Sylvia G. Emmer				Month	Day Year			
·	/Medic				4h Ci	h. Tourn or Legation of Dec	<u> </u>	4c. County of Deat	12:15 PM		
	Examin	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Harmony Hall  Columbia					Howard	(1)		
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56			Usual Residence of Decedent								
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-f ehow ha Modical Examinar mout be notified at	To Be Completed	15. Decedent's Ed	ucation	16a. Decedent's U	sual Occupation	16b	. Kind of Business/	Industry		
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<u>a</u>	should bind Ment		George U. Escobal			Grace E	mma Mackey	·			
Maryland	2 sho and is m		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Addre	ess (Street and Number or R	ural Route Number, Ci	ty or Town, State, 2	Zip Code)		
	and lealth m 27 her ti		John P. Emmerling,		4927 Cle	arwater Dr.			21043		
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐	Removal from State	Place of Disposition (A	or other place)	200	Location - City or			
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	1) MO1443	4112	old Columbia	Pk. Ellic	ott City.	, MD 21043		
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			shock, or heart failure. List only of immediate Cause (Final	one cause on each line.	'	unbalan			Interval Between Onset and Death		
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Box	ath c attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		23d. Date of del Month	elivery Day Year				
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Division of	l or Attan after deatl Director:		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, fact y)	28f. Location (Street City or Town, St					
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	To the Hospital or Attsm within 24 hours after deatl To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
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0	41		29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  5005 Shipnau Bull Lane Claubsulli MD 21029 Suzam Ando								
2.	13		5005 fignal	Bell Lan	e clas	usulle n	10 010	19/30	12cm Hhow		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture	M			, , , ,		
	Registr	ar	MAR & I	LUUD	in prose						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Franciosi Margaret -2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 36 Race Street Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) Jul 19, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 215-20-6473 Yrs Director 78 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other then "naturel", or itema 23a or 28a-f ehow vent, the Madical Examinar must be nutified at MD Allegany Cumberland 1 ¥Yes 2 □ No Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21502 36 Race Street USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: white δ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fite Depertment of Health and Mental Hy Important: if Item 27 is marked other by Injury or other traumatic event Be Marian A. McKenzie Mantheiy Will Franklin J. Mantheiy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
330 Byrd Avenue Cumberland MD 21502 Mark Franciosi son 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's Cemetery 4/1/2006 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nam Sand Adden f Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Party Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 140 (ardra Cz /Medical Due to (or as a consequence of): Examiner Oronga Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the ettending physicien and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performad? KELBASED certificate 20 NO 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide To the Hospitai within 24 hours e To the Funerel I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 86 held on M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 0m15 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2006 **Physician** Helen Maxine Fike March 15, 3:30 p. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Co. Memorial Hospital Oakland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y July 27, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Year 1917 Maryland 1 ☐ M 212 F 214-48-3374 88 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show MD Garrett Friendsville Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1011 Old Selbysport Road 21531 USA filed within 72 hours after death Funeral Herns 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ No Specify: þ Specify: white 3 ₩Widowed 4 □ Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 th Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any fury or other traumatic event 200s, njury or other traumatic event 200s. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawrence Sellers Barbara Ellen Shevel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Fike/son 1011 Old Selbysport Rd., Friendsville, MD 21531 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Steele Cemetery \*4 Donation 5 Dother (Specify) Mar 17, 2006 Friendsville, MD 21. Signature of Funeral Service Licensee Newman Funeral Homes, P.A., PO Box 275 emas 179 Miller St., Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure l week /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last years hie to for as a consequence of Examine physician and stransit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy been signed by the atter in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown <u>Diabetes Mellitus</u> 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes 2 1 No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes → No 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Hospital within 24 hours a To the Funeral I decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical he 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson, M.D., 311 N. 4th St., Oakland, MD 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1 6 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year :32 A.M 06 ALDA LUCILLE GOSSERT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death AlleGAN Umberland
Under 1 Year If Under 24 Hrs.
In Jays Hours Min. MEART SACred HOSPIta 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 M 20 F 194-28-7542 70 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Hampshire Romney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 W. Rosemary Lane 26757 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giv'e Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mark Funk Grace Byers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen L. Gossert/husband 220 W. Rosemary Lane, Romney, WV 26757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Scarpelli Funeral Home, PA 3-29-2006 Cresaptown, MD 4 Donation 5 Other (Specify) Puneral Mone, III - 22. Name and Address of Facility Scarpelli Funeral Home, PA for Home, Romney, WV 26757 21. Signatu of Funeral Service Licensee Shaffer-Warnick Funeral Home, Romney,

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Completed by Funeral

Be

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Examiner

**Funeral** 

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylend Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23a or 28a-f show eny injury or other treumatic event, if a Medical Exercities must be matified an once.

Baltimore, Maryland 21215-0036

the burial-transit within 24 hours after death.

To the Funerel Director; After this certifice completely filled in by the funeral director, i

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

23a. Park. Enter the disease, or compl spock, of heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ications that caused the deat ne cause on each line.  CHRONIC  Due to (or as a consec	OBSTRUC		n mary F	LISEASE	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):				
resulting in death) Last	Due to (or as a consec	juence of):				
if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	l3c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 Ectopic			23d. Date of deli Month	ivery Day Year
Part II. Other significant conditions con COR Pulmonall Dinkely Mel	Heart FAI	sulting in the underlying $\mathcal{L}\mathcal{U}\mathcal{R}\mathcal{E}$	cause given in Part I.	1 ☐ Yes	2□No 3□F	the cause of death?  obably 4 □Unknown
OBesty	xuns			24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 No
25. Was case referred to medical examiner?	Hospital:			ath Check only one		
1 ☐ Yes 2 ☑ No	1 Inpatient 2	ER/Outpatient 3 1	OOA Vursing H	fome 5 ☐ Residence		cify)
1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	250. 2500.00 110.00	,jary sasarras	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, St		ural Route Number,
29a. Certifier 1 Cartifying Phyone) 2 Medical Exami	ner: On the bast of my known and manner stated.	wiedge death occurre ation and/or investigation	d at the time, data and place on, in my opinion, death occu	and due to the cause urred at the time, date a	(s) and manner as and place, and due	to the cause(s)
29b. Signature and title of certifier	remis.	2	9c. License number D 2 5 6 3	8 m	Date signed (Monti	h. Day, Year)
30. Name and address of person who co	4NG WI 7 4	Broadu	vay FROS	tony M.	arylana	1 21532
31. Date filed (Month, Day, Year)	32. Registre's Signal	ature # M	were the same of t			

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 **Physician** Month Robert Dustin Grape March 16, 9:10 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Citizens Nursing & Rehab Center Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
July 14, 1926 Washington, DC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□F 79 Director 579-34-3663 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f ehow The Medical Examinat must be notified at 10d. Inside City Limits Maryland 1xx Yes 2 ☐ No Directo Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1900 Rosemont Avenue 21702 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iteme 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 Marned 1 ☐ Yes 2 录No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Theodore Grape ပ Ella Beane 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essie Freeburn / Friend Health Item 27 I 1713 West 7th Street, Apt. 6, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of March 21, 20c. Location - City or Town, State permit. Pages 'Department of F Important: If Ite eny injury or ot once. Resthaven Memorial 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Gardens Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enterthe disease, or comshock, or heart failure. List only dications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stage Spinocerebellum Degeneration Yrs. /Medical Due to (or as a consequence of): Examiner b. End Stage Parkinson's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Yrs. Due to (or as a consequence of): Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed c. Normal Pressure Hydrocephalus Yrs. resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Neuropathy Yrs. as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ned by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signed should be d Immobility Syndrome, Chronic Aspiration, Squamonous 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Cell Cancer of Nose, Osteoporosis, Depression, 24a. Was an 2 X No Dementia 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide

P.O. Box 68760. Division of Vital Records, To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

Baltimore, Maryland 21215-0036

HIVA

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Reilly, M.D. 801 Toll House Ave., D-1, Frederick, MD 21701

and manner stated

31. Date filed (Month, Day, Year)

29a. Certifier

Medical

gistrar's Signature

Registrar

1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 54749

29d. Date signed (Month, Day, Year)

March 20, 2006

CPM 06-02115 Timothy Hamm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a, 27, 28a-f, pen/F, 6854, 46/06 TT

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	-		Matri au	on: -to	lle us	0	C.M.I	Ξ.	Ma	arch 27,	2006	
			30. Name and address of person wh	o completed cause of	death (Item 23a) (Type	Penn Str	eet, I	Baltim		cyland 2		
M	Sta Registr		31. Date filed (Month, Day, Year)		trar's Signature	Grande					1	

			1 - For State Registrar	State of Maryland / D		Health and M	lental Hyg	jiene	) K	1099	23
_		_	Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of	Death	2. Date of Dea	eg.:No.	<i>J U</i>	3. Time of	U
	Physicia /Medic			Edgar Hudson, J	r.	,	Month	Day 25	2006	1005	A M
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	Funeral Director		214-14-7464		hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day) March 1	, Year)	9. Birthp Court De:	ilace (State or itry) Laware	Foreign
	and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				1	0d. Inside Cit	y Limits
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	3a of		464 Muddy Lane		21921			Uni	ted St	ates	
	death ms 2	Funeral		12. Was Decedent Ever in U.S.	13. Was Decedent of If Yes, specify Cut		ecify Yes or No-		ace - Americ	an Indian,	
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a	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service License		22 Name and Addr Hicks Hom	ess of Facility e for Fune ockton Str	erals. P	. A .			
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			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ations that caused the death. Do not be cause on each line.	ot enter the mode of dy	ing, such as cardiac	or respiratory arr	est,		Approximate Interval Betwonset and D	veen
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X D	ath ce ttendi	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnance	су			Date of deliver	*	'ear
_	the death by the atter ached for u	Physician/M	1 Yes 2 No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)						
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	ital or A rs after rai Dire led in by	Cer									
	To the Hospital or All within 24 hours after or To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical Examin	sician: To the best of my knowledge, nar: On the basis of examination and							
	To the within 2 To the complet	Med	one)  29b. Signature and title of certifier	and manner stated.	29c. Licen	ise number	2	9d. Date sign	ned (Month.	Dav. Year)	
	F 3 F 8		Days tile	PelC/M-7ml,	1 2-	ngerly		Marso	4 28	3,20	06
4	1-1		30. Name and address of person who co	mpleted cause of death (Item 23a) (	Type, Print)	7	1				
6	71		SATANTICA	LKATELA	11) 1235	ngerly	Hie,	Elk	1074/	n1)21	921
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signature	barlis	0 1	7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 6 per fh 24a per mr 2854 4-3-06 yt.

State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death Reg. No. UUD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Alta F. Harrison /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CUMBER If Under 1 Year I If Under 10 AR+ SACred GANI 8. Date of Birth (Month, Day, Ye 1/12/24 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace State or Foreign Country)

WV **Funeral** Months Days 1 M 2 XF Yrs. Director 233-34-6185 82 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show traumatic event, the Madical Examiner must be notified at Director 1X Yes 2 □ No WV Mineral Keyser 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 144 E. Piedmont Street 26726 or iteme 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify þ If Yes, Give Year or Dates: Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If Itsm 27 is marked other then eny Injury or other traumatic event, Its Ma once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bruce Montgomery Bertha Ravenscroft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willard Harrison/husband 144 E. Piedmont St., Keyser, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/31/06 Potomac Memorial Keyser, WV 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Markwood Funeral Home, Inc. P.O. Box 912, Keyser, WV 26726 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ance. /Medical Examiner mont Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? t ☐ Yes 2 ☐ No Month Day 4☐ Pregnant at time of death 5 Other (specify) ed by the s deteched f 9 Unknown Part II. Other significant conditions cont witing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 24 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate hes l page 2 s autopsy performed? Yes 2 No 1 Yes 1 Yes 2 No Director: After this certific d in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; 28c. Injury at Work? 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours aft To the Funerel DI completely filled in 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, M DR. John Mehanna 900 DRIVE SETON 31. Date filed (Month, Day, Year) --State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

2006

	1	For State Registrar		State of	Marylar	-		nt of H		and M	ental H	ygiene Reg. No	006	102	225
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/Medica		4a. Facility Name (If not				Опшан	4b. Cit	y, Town, or	Location of		maich		County of Death	1:10	<b>P</b> M
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Funeral		5. Social Security Numb 218-24-8822	per 6. Se			last birthday) Yrs.	If Und Month	er 1 Year	If Under:	24 Hrs. Min.	8. Date of B	irth		lace (State	or Foreigi
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yland		10a. State 10	b. County		10c. Ci	ty, Town or Lo	cation						1	Od. Inside C	City Limits
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s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mantal Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event. Its Mailest Examiner must be notilized.	<u>ख</u>	11. Marital Status	TIE NOA	12. Was Decede	ent Ever in U	IS 13 1	Vas Dec			ain? (Sne	cify Yes or N		SA I. Race - Americ	an Indian	
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and 27 m 27 her tra		David Hohma			lan, r				Ave.		urmont				
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permit. Pages 1 and 2 Department of Health a Important: If Item 21 is any injury or other tra once.	1	AUSA (	MU	Le						DLO			ral Home		
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 350pm March RUSSELL EUGENE HIGDON 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 X M 2 □ F Yrs. Director 216-30-2934 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 28a-f show other treumatic avent, the Mudical Examiner must be notified at Completed by Funeral Director 1 ☐ Yes 2 ☑ No MARYLAND WASHINGTON KNOXVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1712 ROHRERSVILLE ROAD 21758 Items 23a U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No 1952—
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 Divorced 1954 Year or Dates: WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CLERK RAILROAD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F BRUCE LEONARD HIGDON MILDRED SOPHIA SPENCER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 PHYLLIS J. HIGDON/SPOUSE 1712 ROHRERSVILLE ROAD, KNOXVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H
Important: If Its
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 5 Other (Specif 4 Dogath BROWNSVILLE HGTS. CEM 03/27/2006 BROWNSVILLE MARYLAND 21. Signature of 7606 old National Pike BAST FUNERAL HOME Paul M. Dean Boonsboro, Maryland 21713 emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preum onea **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the buriel-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Certification: To Be Completed 1 ☐ Yes 2 ☐ No 3 robably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Arvie Renul 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to 11 edical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes atient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending To the nosperation death.

Swithin 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determin 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) B 40000000 elecue ( 2+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Essi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra 1-Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician **Imes** Jr. 25, <u>11:</u>42 John Russell MARCH 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Jun 23, 1962 9. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F Yrs. 212-52-5987 43 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD Allegany Oldtown 1 Yes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 5 21555 24500 Gorman Road SE USA Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 ō Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental I Mildred D. (Gordon) Imes John Russell Imes Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health a Important: if Item 27 le eny Injury or other trai **Dolores Michaels** 24500 Gorman Road SE Oldtown MD 21555 sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 3/30/2006 Restlawn Memorial Gardens LaVale MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signatur of Funeral Service Li - nsec 108 Virginia Avenue: Cumberland, MD 21502 23a/Pan'l Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HYPERTENSIVE ATKERO SCIEROTIC WARDIOVASCURAR disease or condition resulting in death) /Medical Due to (or as a consequence of): DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 1 Yes 2 🗆 No : After this certifical funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ¶XYes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending death. 1 Tyes 2 No investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) within 2 the st 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E MARCH 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUBIO, MD 111 PENN STREET, BALTIMORE, MARYLAND 21201

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 3 2006

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 23 Day 2006 Mollie F. 6:15 A M Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral**  Birthplace (State or Foreign
Country) Months 1 □ M XXF Director 230-54-0016 90 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
ther than "natural", or itame 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itame 23a or 28a-f ehow other traumatic event, the Madical Examiner roughly national 10d. Inside City Limits 1 ☐ Yes 2 No Director Virginia Page Stanley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 265 AI Good Dr. 22851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) t 2 should be fited w h and Mental Hygier 7 is marked other th Clerk Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ం Sameul W. Fletcher Minerva E. Toliver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is rr eny injury or other traum once. <u> I. Carol Nash - Daughter</u> 11354 Greenridge Dr. Waynesboro, Pennsylvania 17268 20a. Method of Disposition
112 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Mar. 28, 2006 Brentwood, Maryland 21. Signature of Fureral Service Licenses Osborne Afunctativ Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the dist ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final ANDIOVASCUCAN Physician disease or condition resulting in death) On /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed signed by the attending physician and diedetached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other agnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Yes 2 No certificate 2 🗆 No 1 🗌 Yes 1 Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Natural Accident Injury 5 Pending death investigation 1 ☐ Yes 2 ☐ No Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1A Certifying Physician. It the best of my linewisedge, death convired at the time, date and place, and due to the cause(s) and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation in municiping death. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signati 29c. License number 29d. Date signed (Mogth, Day, Year) 1)mcco ue dicin mpleted cause of death (Item 23a) (Type, Print) METENIA and 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			State State Registra AMEND#23a(b/c)penMD3/2	of Marylan					ınd M	-	2)	200	10000
			Decedent's Name (First, Middle, Last)	20/00/11 31/1	10000	incare	OIL	Calli		2. Date of De	Reg. No.	JUD	3. Time of Death
	Physic /Medi		Genevieve M. Jones	,	,					March	$1^{Day}$	2006	6:35P. M
	Examir		4a Facility Name (If not institution, give street and n 11906 Gordon Avenue	umber)		4b. City, Be	own, or Ltsv	Location of	f Death			county of Death	George's
	Funeral Director		5. Social Security Number 578-26-9159 6. Sex 1 □ M 2 🕅 F	7. Age (In yrs.	last birthday) 81 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt Jan. 8,	923	9. Birth Wash	place (State or Foreign mary) ington, D. C.
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c Cit	v. Town or Lo	nation							
	ie Marylan Ba-f ehow diffied at	ctor	Maryland Prince George	s Be	y, Town or Lo ltsvil	le							10d. Inside City Limits 1 ☐ Yes 2 No
	death with the Maryland ma 23a or 28a-f ehow rmust be notified at	Funeral Director	11906 Gordon Avenue			10f. Zip	Code 2(	0705				ted Sta	
980	hours after dea tural', or itema al Examiner m	Þ	Armed F	2√ No live		Was Deced If Yes, spec	V	spanic Orig n, Mexican, Specify:	in? (Spe Puerto I	cify Yes or No- Rican, etc.)		4. Race - Ameri Black, White Specify:	
5-0	72 hc	etec	15. Decedent's Education (Specify only highest grade completed	)	16a. Dece	dent's Usua kind of word DO NOT us	Occupat k done du	tion uring most	of workir	ng .	16b. Kin	d of Business/Ir	ndustry
2121	ad within rgiene. ar then	Completed	Elementary/Secondary (0-12) College	(1-4or 5+)	Homem.		e retired)				0	wn home	
Maryland 21215-0036	uld be filed fental Hygie rked othar tic event, the	To Be	17. Father's Name (First, Middle, Last) Hunter	Hibbert				18. Mother Marg		(First, Middle, te	Maiden S	'umame)	Buckley
	s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked othar ther other treumatic event, the Mental the the state of the the the state of the the state of the stat		19a. Informant's Name/Relationship (Type, Print) Paul E. Jones -son									Town, State, Zij	
ore,	of Hear		20a. Method of Disposition		Place of Dispo	sition (Nam	e of			ate		ation - City or T	
imo	Per in		1 ⚠ Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)						mete	ry 3/15	/200	6 Belts	ville,MD
Baltimore,	permit. Peges 1 and 2 s Department of Health ar Importent: if Item 27 is eny injury or other treu		21. Signature of Funeral Service Licensee	ant	22 Do 44	nald	V. E	of Facility	ardt	Funera	1 Hou	ne, PA	yland 20705
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	caused the death	n. Do not ent	er the mode	of dying,	, such as c	ardiac o	respiratory ar	rest,	ie, nar	Approximate Interval Between
	Physician	Immediate Cause (Final disease or condition resulting in death)  a. Cardro pulmo hand arrest											Onset and Death
	/Medical Examiner		resulting in death)  Due to	(or as a consequence Stage R									
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	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  Conc	gestive H	Heart 1	Failui	e e	<del></del>	dict	110	-		
,00	ate be executed thysicien and the burial-transit	Exa	resulting in death) Last Due to	(or as a consequ	uence of):								
8760,	cate be ex physicien ; the buria	dical	d										
P.O. Box 6	that the death certificate be execu led by the ettending physicien and deteched for use as the burial-tra	Physician/Me	in the past 12-months?	utcome of pregna birth 2 Fetal mant at time of de nown	death 3	Ectopic pre Other (spe					23	d. Date of delive Month	ery Day Year
	requires that the een signed by th nould be deteche		Part II. Other significant conditions contributing to	death but not resu	ulting in the u	nderlying ca	use giver	n in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?
ords	w require been sig should b	ed b								1 🗆 Y	es 2 🗆	No 3□ Prot	pably 4 Unknown
Division of Vital Records,	e law hes b	Completed by				·			_	24a. Was a autop perfor	an sy med? 2. △No	24b. Were auto prior to co death? 1 \(\sum \) Yes	opsy findings available impletion of cause of
/ita	ysician: Th is certificate director, pag	ВеС	25. Was case referred to medical examiner?					26. Place	of Death	(Check only or		10,103	20,140
of\	× 0 70	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐		ER/Outpatien			4   Nui:				Other (Specif	(v)
on	Attending r death.	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	of Injury oth, Day Year)	28b. Time of Injury	M 28	c. Injury a Work?	at es 2.∐N	1	8d. Describe h	ow injury	occurred	
visi	Atter octor by the	Ifica	3 Suicide 6 Could not be 28e. Place	e of Injury - At ho	me, farm, str					8f. Location (S	treet and	Number or Rura	al Route Number.
Ö	tel or rs afte el Dir led in	Cert	Bulk	ling, etc. (Specify	<i>'</i> )					City or Tow	n, State)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the 2 Medical Examiner: On the and ma	e best of my know basis of examinat nner stated.	wledge, death tion and/or inv	occurred a restigation, i	the time	, date and nion, death	place, a occurre	nd due to the c d at the time, c	ause(s) a late and p	nd manner as s lace, and due to	tated. the cause(s)
		W	29b. Signature and title of certifier			29c.	License D6	0100		Z		signed (Month, h 13, 2	
	8		30. Name and address of person who completed cat Tahmina Khanam Ahmed, M	se of death (Item	23a) (Type, Univer	Print)	B]vd	#2	7 Si	lver S	orino	Marul	and 20003
	Sta Registr			Registrar's Signal				7 112		-2401 0	- 111E	,, raryı	.and 20303
P.	110913(1		MILES ~ 0 7000	CHAI SH									

		•	1 - For Stata Registrar	State of Mai		artme		ealth and	Mental Hy		006	10231
	100		1. Decedent's Name (First, Middle, Las	st)					2. Date of De	ath		3. Time of Death
	Physici	_	LYNN MARCHON	E KANASKI	Ė				Month	Day 14		3:55A M
	/Medic Examin		4a. Facility Name (If not institution, give			4b. Cit	y, Town, or	Location of Deat	1		County of Dea	th
	LXaiiiii	(C)	Montgomery Hospie		use	R	ockvi	11e			Montgom	
7	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Und	er 1 Year	If Under 24 Hrs	8. Date of Bir	th		thplace (State or Foreign
	Director			□M 283F 55	Yrs.	Month	Days	Hours Min.	Oct.3.	1 <i>y, Year)</i> 195	0 Was	shington, DC
	D		Usuat Residence of Decedent								- 1	ming cont bo
	how		10a. State 10b. County		10c. City, Town or Lo	cation						10d. Inside City Limits
	e Ma	cto	PA Bedford		Clearvi	11e						1x Yes 2 No
	or 28	Director	10e. Street and Number			10f. 2	ip Code			10g. Cit	izen of What Co	ountry?
	death with the Maryland ms 23a or 28a-f show		921 W. Mattie Ro	ad			L5535			U.	S.A.	
	dea F	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S. 13.	Was Dec	edent of Hi	spanic Origin? (S	Specify Yes or No to Rican, etc.)	o-	14. Race - Ame Black, Whi	
2	or it		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give				Specify:	,		Specify: Wh	
Š	be filed within 72 hours efter death with the Marylan Hygiene.  do other than "neturel; or items 23s or 28s-f show event, the Markical Examiner chart be notified at	d by	3 Widowed 4 Divorced	Year or Dates:				Op don'y.			Specify. VII	
21215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece (Give	dent's Us kind of v	ual Occupa vork done d	ition luring most of wo )	rking	16b. K	ind of Business	/Industry
Z	han han	μ	Elementary/Secondary (0-12)	Cotlege (1-4or 5+	)			)			D	
N	filed v Hygie Sthert ant, th	ပိ	12th 17. Father's Name (First, Middle, Last)		н	mema	iker	10 Markada Ma	me (First, Middle		Domest	LC
بعم	be fi	Be		_							_ ,	
2	should be nd Menta marked imatic ev	မ		Pappas				Joseph		ouse		
<u> </u>	12 sh and raun		19a. Informant's Name/Relationship (			7.0			ural Route Numb	_		
a)	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury openher traumatic evonce.		Donald K. Kanaski  20a. Method of Disposition	e/Husband					learvil			
saitimore,	るっきまり		1 Burial 2 Cremation 3	Removal from State	20b. Place of Dispo cemetery, crea						ocation - City or	
	tant:		4 □ Donation 5 N Other (Specifi	Entombment					20/2006		ls Chur	
Sa	ermit Seper Inpor Iny in		21. Signature of Funeral Service Licer	360								L HOME, INC.
	005 e d		Nancy A. T	macen -							er Spri	ng, MD 20904
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Astrocy			ode of dynn	y, such as cardia	c or respiratory a			Approximate Interval Between Onset and Death
Ů,	ite be executed lysicien and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):							
-	ate by nysici he bu	Icai		d								
.C. Box 68	it the death cerificat by the attending phy tached for use as th	Physician/Med	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic Other (	pregnancy specify)	-			23d. Date of de Month	livery Day Year
s,	E BB	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying	cause give	en in Part I.	23e. Did	tobacco i	use contribute t	o the cause of death?
SD	w requires been sign should be								1 🗆	Yes 2	No 3∏P	robably 4 Unknown
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	n: Ti ficete r, pa		OF Was asset and the section of						1 ☐ Yes		1 ☐ Ye	2 No
Vitai	Physicien: The law this certificete has b ral director, page 2 s	o Be	25. Was case referred to medical examiner?	Hospital:			Othe	30	ath (Check only			TT .
ō	<b>₽</b> ~ @	<b>-</b>	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 Inpatient			- A	4 🗀 Nursing i	Home 5 ☐ Res 28d. Describe			ecify) Hospice
	ding l	Fig.	1 X Natural 5 ☐ Pending	(Month, Day	Year) Injury	М	28c. Injury Work	(?` Yes 2 □ No	EGG. BOSGIBO	now mydi	iy oodaned	
Division	ei or Attending s after death. it Director: Afte id in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		y - At home, farm, st (Specify)				28f. Location City or To			ural Route Number,
	To the Hospitel or / within 24 hours after To the Funeral Dire completely filled in b	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	h occurre vestigation	ed at the time on, in my op	ne, date and place pinion, death occ	e, and due to the urred at the time	cause(s)	) and manner a d place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier			2	9c. License	number		29d. Da	te signed (Mon	th, Dey, Year)
)	1		1-14-1	~ ~	2		D-356	35		Marc	ch 15,	2006
	6		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	· ·						
			Joseph Kaplan, N		Muncaster	Mil.		d, Rockv	ille, M	aryl:	and 208	55
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 0 7	32 Pegistrar	's Signature	celle	,					

			_ For	State of I	Marylan	d / Depa	artment of I	Health a	and M	ental Hyg	giene	Ü		
		•	1 - State Registrar			Cei	rtificate of	Death			Reg. No.	006	102	32
	Physicia	an.	Decedent's Name (First, Middle,	Last)	17	. 1				2. Date of Dea Month	Day			of Death
	/Medic	al	Rose		Kam	ет	4b. City, Town,	or Logation o	of Dogth	March	11	2006 County of Deat	6:00	Α. "
	Examin	er	4a. Facility Name (If not institution, Suburban Hospit		91)		Bethes		DI Deatii			ntgomer		
	Funeral			6. Sex 7.	Age (In yrs.	last birthday)	If Under 1 Year Months Days	r If Under	24 Hrs. Min.	8. Date of Birth (Month, Day	h	9. Birt	hplace (State untry)	or Foreign
	Director		None	1□M 2\DF	91	Yrs.	Months Days	Hours	IVIIII.	Nov. 17	, 19	914 Eg	ypt	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside	City Limits
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	r 28e	rect	10e. Street and Number	mery	Jul	CHCLSD	10f. Zip Code				10g. Citi	zen of What Co	untry?	
	th with	Funeral Directo	6050 Olney Layt	onsville F	Road		208				Egy	ypt		
	r dea	ner	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori ban, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Ame Black, Whit</li> </ol>		
20	rs afte	by Fi	Never Married 2 Marrie  3 Widowed 4 Divorced	ed 1 ☐ Yes 2√ If Yes, Give Year or Date			1 ☐ Yes 2 🗓 No	Specify:	:			Specify:	White	
200-c	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or Itema 23a or 28e-f show int, the Madical Exercit of mantice notified a		15. Decedent			16a. Dece	dent's Usual Occu	upation	t of work	000	16b. Ki	nd of Business/	Industry	-
7	thin 7	Completed	(Specify onfy highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retir	ed)	or work	,,,9				
7	led wi lygien her th		11	-55)		Homem	aker	18 Moth	or's Name	(First, Middle,		1 Home		
yiana	i be fi ntal H ed ot	Be	17. Father's Name (First, Middle, L Kamel Nakhla						eena	Elias		ourname,		
Š	Should nd Me merk matk	2	Kamel Nakhla  19a. Informant's Name/Relationsh			19b. Mailie	ng Address (Stree					r Town, State, 2	Zip Code)	
Z Z	alth ar		Nayer Kamel/Nep	hew		1140	2 Beehiv	e Cour	rt, (	Germanto	own,	Md. 20	876	
Бапптоге,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The man and Injury or other traumatic event, the Marilest Exercit or must be notified at once.		20a. Method of Disposition  1 Bunal 2 Cremation	3 □Removal from St		Place of Dispo cemetery, crea	osition (Name of matory or other pl	ace)		h 13,	20c. Lo	cation - City or	Town, State	
Ĕ	ment tant: I had		`4 □Donation 5 □ Other (Sp	ecify)	T		eaven Ce	m.	2006			ver Spr	ing, M	d,
g	Department mportment in hora		21. Signature of Funeral Service L	censee			oney & K	-						
	40144		23a. Part1. Enter the disease, or	complications that cau	sed the dear	th. Do not ent	71 W. Ma	ple Av ving, such as	re., cardiac	Vienna, or respiratory ar	Va.	. 22180	Approxim	ate
	Physician		shock, or heart failure. List of Immediate Cause (Final	only one cause on eac	:h line.	e .							Onset an	
	/Medical		disease or condition resulting in death)		as a consec									
	Examiner		Sequentially list conditions.	b										
7	pe is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence of):								
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or	as a consec	quence of):								
2/PN	s be (	icai		d		_								
Q Q	ntifical ng phy as th	ਰ	IF FEMALE:											
X Q Q	ath ce ittendi	Physician/Me	23b. Was decedent pregnant in the past 12 menths?		h 2 ☐ Feta	al death 3	⊒Ectopic pregnan	псу				23d. Date of de Month	livery Day	Year
- :	he de the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐Unknow	nt at time of one	death 5t	Other (specify)							
ı.	w requires that the death certific: been signed by the attending pl should be detached for use as t		Part II, Other significant condition	ns contributing to dea	th but not re	sulting in the u	underlying cause o	given in Part	l.	23e. Did to	obacco i	use contribute to	the cause o	of death?
ecords,	quires	ed by	Hypertens	ion, hip	tr	actu	re			101	Yes 2	No 3□P	robably 4 [	Unknown
ပ္ပ ပ	law re as bee 2 sho	Completed	/1							24a. Was autop		24b. Were an	utopsy finding completion o	s available cause of
Y.	The ate h page	Com								perfo	rmed? 2 No	death?	2 100	
Vital	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:				ther		h (Check only o		-		
0	Phys r this ral dir	7	1 X Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatie	III 3L DOA	4 🗀 N	ursing Ho	me 5 Resident			cify)	
	tending fleath. Ior: After the funer	tion	1 Natural 5 Pendin 2 Accident investig	Month.	Day Year)	unkno	own 11	lork? □Yes 2	No	(all	/			
Division	r Atter er dea rector by the	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ot be 28e Place o	1	nome, farm, st	reet, factory, offic	0		28f. Location (	Street ar	Number of R	ural Route N	Lay tois
5	itel or irs aft ral Di			home	e					ville Ro	-	aithers	burgi,	MD
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physician: To the b Examiner: On the bas and manne	is of examin	owledge, deal ation and/or in	th occurred at the nvestigation, in my	time, date a opinion, de	nd place, ath occur	and due to the red at the time,	date and	) and manner a d place, and du	s statetk e to the cause	B(S)
	o the	Med	29b. Signature and title of certified		111	12	29c. Lice	nse number			29d. Da	te signed (Mon	th, Dey, Year	)
	1		Patricia	10mske	- 16	ay, me	D L	1519	16		Mai	rch l'	7,200	06'
	1		30, Name and address of person	who completed cause	of death (Ite	m 23a) (Type	Print) //	n.L.	0	-100 1	ban	Lu:11.	MID 1	1000
			31. Date filed (Month, Day, Year)	SKO VAY	gistrar's Sign	Koc	KVIIIE	PINE	16	100, 1	100	VIIIE	111/2	ひひろん
	Sta	ite	MAR 2 0	2006	o organ	K An	esti?							

Loechel

Yrs

7. Age (In yrs. last birthday)

93

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Accident

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min.

1. Decedent's Name (First, Middle, Last)

4a. Fecility Name (If not institution, give street and number)

Cherry Hill Assisted Living

6. Sex

Lucretia

1 ☐ M 2 ☐XF

Mildred

5. Social Security Number

214-03-7115

**Physician** 

/Medical

Examiner

**Funeral** 

16b. Kind of Business/Industry Telephone Company 18. Mother's Name (First, Middle, Maiden Sumame) Rhoda (Messersmith) 195 Mailing Address (Street and Number or Rural Route Number, City, or Town, State, 7th Code, P.O. Box 294 Grants VIIIe MD 21536 Date 20c. Location - City or Town, State 3/31/2006 MD Grantsville 22. Nam Staffellir Fürreral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Y ENAS 23d. Date of delivery Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify SSISTED 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 15. Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D42054 March 28, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gregg C. Donaldson, M.D.; 912 Seton Drive; Cumberland, MD **ORIGINAL** 

2. Date of Death Mar 28, 2006

Date of Birth Oct 9, 1912

4c. County of Death

10g. Citizen of What Country?

USA

14. Race - American Indian, Black, White, etc.

Specify: white

Garrett

5:30 am м

9. Birthplace (State or Foreign

10d. Inside City Limits

1 X Yes 2 ☐ No

State Registrar

10

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** W. MARCH 27, 2006 HEINZ LENZ 1:30 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SUNRISE ASSISTED LIVING SEVERNA PARK
If Under 1 Year If Under 24 Hrs. ANNE ARUNDEL 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**∑**M 2□F 80 Yrs. Director 047 16 4125 Germany MAR. 31, 1925 Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Items 23a or 28e-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Maryland Anne Arundel Annapolis Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21409 USA 506 Fawns Walk Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ill Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after d. ta! Hygiene. d other then "natural", or Item 1 Myes 2 □ No If Yes, Give Year or Dates: 1943–85 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2X No δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Naval Academy Professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Amalia Goldmann Frederick Walter Lenz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Heelth a ent: If Item 27 is ury or other trea 506 Fawns Walk, Annapolis, MD 21409 Bette C. Lenz/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-29-06 KALAS CREMATORY EDGEWATER MD 21. Signature of Fundat Strvice Licensee 22. Name and Address of Facility GEORGE P. KALAS FUNERAL HOME 2973 SOLOMONS ISLAND ROAD EDGEWATER, MD. 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PARKINSON'S **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initialed events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. Il yes, outcome ol pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the resolut, page 2 should be detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ၉ 1 Yes 2 No 3 DOA S C 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: LIVING Natural 2 Accident 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funaref D 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Dan MARCH 27,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 3169 BRAVERTON ST, Ste 201 EOGEWATER KAYMOND E BANFER 32 Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

2006

			1 - For State Registrar	State of Maryland		artment of H		Reg	/No. ) ) (	10235
	Physici	an	Decedent's Name (First, Middle, La	st)				Date of Death     Month	Day Year	3. Time of Death
	/Media	cal	ROBERT EUGENE	LEWIS SR.				MARCH 17	2006	8:15 P <sup>M</sup>
4	Examir	ier	4a. Facility Name (If not institution, giv				Location of Death		4c. County of Dea	
			4934 PORTERSTOWN 5. Social Security Number 6. S	<del></del>	ast hirthday)	If Under 1 Year	eedysvil			ington rthplace (State or Foreign
	Funeral Director			IM 2□F	6 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y JUNE 29.	1929 M	ARYLAND
			Usual Residence of Decedent					OUNE 27,	1747 1	AKTUAND
	ith the Marylan or 28a-1 show re notified at	_	10a, State 10b, County	10c. City	r, Town or Lo	ocation				10d. Inside City Limits
	8a-1 s	cto	MARYLAND WASHING	GTON		KEED	YSVILLE_			1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What C	ŕ
	s 23a	rai	4934 PORTERSTOWN	ROAD  12. Was Decedent Ever in U.	6 10	W B d4 -411	21756	and VN-	U.S	
	after des	Funeral Director	11. Marital Status 1 □ Never Married 2X Married	Armed Forces?		Was Decedent of H If Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Wh	
036	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 195		1 ☐ Yes 2X No	Specify:		Specify:	нтте
5-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-1 show idical Examinet: was be roullied at	Completed	15. Decedent's E (Specify only highest gra		16a. Dece	dent's Usual Occup	ation	16	b. Kind of Busines	
2	within 7 ene. than "r	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	t)	arig		
21	filed with Hygiene. ther thai		8		HEAV	Y EQUIPME				RUCTION
Maryland	should be filed withir nd Mental Hygiene. marked other than imatic event, the Ma	Be	17. Father's Name (First, Middle, Last					e (First, Middle, Ma	tiden Sumame)	
2	hould be d Mental narked o natic eve	2	THOMAS L. LEWIS :		10h Maili	na Address (Street	SUSAN L.		Site of Town Chair	7:- 0-1-1
Ma	2 6 5 6		LINDA C. LEWIS/S	**		-		al Route Number, (	-	YLAND 21756
ō,	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			C. Location - City o	
ο̈́	ages ant of it: If it		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	JHemoval from State		matory`or other plac	1			
altimore,	permit. Page Department Important: hany injury o		21. Signature of Funeral Service Uce	psee MOU		VIEW CEM  2. Name and Addres	ss of Facility		HARPSBURG National	MARYLAND
ñ	permi Deper impo any ir		I WILL	Paul M. De	ean B	AST FUNER	AL HOME		o, Maryla	
			23a. Part . Enter the disease, worm shock, or heart failure. List only	pplications that caused the death	. Do not en	er the mode of dyin	g, such as cardiac			Approximate Interval Between
8	Physician		Immediate Cause (Final disease or condition	Chronic 36	struc	tive Pu	lminova	diseas	P	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ	uence of):		lminory	311 000		
	Examiner	١.	Sequentially list conditions	Coronary	arte	my discu	21C			years
	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			cytic le		. ,		LOGAN
	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Chronie Due to (or as a consequ		egue u	eukemio			gewos
8760,	be executician and burial-tran			000 10 (07 43 4 001134)	26/100 Qr).	$\mathcal{U}$				asas
687	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medical		d						1
Вох (	eath certific attending pl	Z M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	alivery
ğ	death a atte d for	iciai	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de		□Ectopic pregnancy □ Other <i>(specify)</i>			Month	Day Year
0	that the de	hys	9 Unknown	9□ Unknown						
Ö,	ires tha signed d be del	by P	Part II. Other significant conditions	contributing to death but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ord	w require been sig	ed						1 ☐ Yes	2 □ No 3 □ 4	robably 4 \(\sum \)Unknown
Records,	law reas be	Completed						24a. Was an	24b. Were a	utopsy findings available
H		P						performe	od? death? ZNo 1 ☐ Ye	completion of cause of s 2 No
Vital	Physician: The law this certificate has be ral director, page 2 s	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		
of \	hysi this o	은	1 ☐ Yes 2 ☐ No		ER/Outpatie		4   Nursing Ho			ecify)
n o	ng After Ine	on:	27. Mann of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe how	injury occurred	
Sic	Attending r death. ector: After	icat	2 Accident investigation 3 Suicide 6 Could not be	OB OBS Dises of laive. At he			Yes 2□No	284 Location /Stee	at and Number of C	Pural Couta Alumbar
Division	or A after Direc	Certification:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	()	eet, ractory, office		City or Town,	State)	Rural Route Number,
	spital ours neral filled		29a. Certifier 1 Certifying Pl	hysician: To the best of my kno	wiedge, deat	h occurred at the tin	ne, date and place.	and due to the cau	se(s) and manner a	s stated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	edicai	(Check only 2 Medical Examone)	miner: On the basis of examinat and manner stated.	tion and/or in	vestigation, in my o	pinion, death occur	red at the time, date	e and place, and du	e to the cause(s)
	To the Swithin 2 To the complet	M	29b. Signature and trie of contifier	11.1		29c. Licens	e number	290	I. Date signed (Mor	th, Day, Year)
	46			3/10/01		D 60	62123		3/20/och	
_	141		30 Name and a to ess of pers in who	completed cause of death (Item	23а) (Туре,	Print)	. 117	- 1/1	+ + 7	2:-111
	41.		DR TRAVEER	DOLARU	M	340	W1112	1.9741	- MD	21740
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture	Resident				
	Regist	(4)	MAN W - EL	Will profession with	100					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Martin Margaret 25 MARCH 2006 1935 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Couptry) 8. Date of Birth **Funeral** Months Days Hours Min Oct 22: 1923 1 M 2 XF 218-12-5305 82 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Iteme 23s or 28s-f show the Medical Examinar must be notified at MD Allegany Cumberland Director 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Arundel Street 21502 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper A.B. Dick permit. Pages 1 and 2 should be filed a Department of Heelth and Mental Hygie important: if Item 27 is marked other eny injury or other traumstic event, in 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Arthur Connell Letha (Ambrose) Connell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4100 Shatzer Street Chambersburg PA 17201 19a. Informant's Name/Relationship (Type, Print) Teresa Giffin daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State St. Mary's Cemetery 1 Burial 2 Cremation 3 Removal from State 3/30/2006 Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Nam Scandelli Füneral Home, PA 108 Virginia Avenue. Cumberland, MD 21502 23a. P5r 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, in heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition Physician neumonic days /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bading to initial clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit ettending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ğ Month Year Day 5 Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 8 rementi 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Únknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificete 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tes 2 No by the f 2 ☐ Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours efter To the Funerel Dire filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) MARCH 28 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Highway, LaVale, MD 21502 Dr Shiv Nationa 1221 E 31. Date filed (Month 32. Registrar's Signature State 2006 Registrar

		For State Registrar		State of Ma	aryland		artment of F rtificate of		Mental Hy	/giene Reg. No.	006	10237
Physicia /Medic		1. Decedent's Name (First, Mabe	1	E. 11	Mille	r			2. Date of De Month	ch 2	6 2006	
Examino Funeral Director		5. Social Security Number 160-16-4403	6. 9ex	Hospi	(In yrs. la:			gers to w M  If Under 24 Hrs  Hours Min.	8. Date of Bi	rth ay, Year)	9. Birth	ng for nplace (State or Foreign untry)
anyland ehow	-	Usual Residence of Deceder  10a. State 10b. Co	unty		10c. City,	Town or Lo						10d. Inside City Limits 1 2 Yes 2 □ No
vith the M	Director	10e. Street and Number	shingt			naye	orstown  10f. Zip Code	740		10g. Citiz	ten of What Co	untry?
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28e-1 show or other traumatic event, the Medical Examinal Evantile and other traumatic event, the Medical Examinal Evantile and other traumatic event.	by Funeral	333 Mill :  11. Marital Status  1 □ Never Married 2 □  3 ☑ Widowed 4 □ Divo	Married 1	2. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	1740 Hispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		USA  4. Race - Amer Black, White Specify: Whi	ncan Indian, e, etc.
d within 72 hou giana. In than "natura It e Medical E	Completed	15. Dec (Specify only h Elementary/Secondary (0- 12	-	ation completed) College (1-4or 5	+)	(Give lif <b>e</b> . l	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo d)	rking		d of Business/l ufactur	
2 should be filed withir and Mental Hygiene Ie marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Mic		B. Byers	S				me (First, Middle ne K. M		,	¥
1 and 2 sho Health and I em 27 ie ma		19a. Informant's Name/Related Ronald R. Sn				50 Ea	ast Side	Drive, G	Greencas	tle,	PA 172	. 25
Pages 1 ment of He ant: If iter ury or oth		20a. Method of Disposition 1		emoval from State	Sten	ce of Dispo netery, cren ger H	sition (Name of natory or other pla ill Cemet	cery Mar	30,2006		Loudon .	
permit. Page Department of Important: if any injury or once.		21. Signature of Fucur V Ser	-1	nes .		22		ss of Facility Li	ninger-	Fries	Funera	al Home Inc
Physician /Medical Examiner  but still physicien end is the but al-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. b. c. d.	Due to (or as a	a conseque	nce of):	Failu Fibr obstr	nationative	hand	9 6	); sease	Onset and Death
v requires thet the death certif been signed by the ettending should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t 23	ic. If yes, outcome of the line of the live birth at 9 Unknown	2 Fetal d	eath 3	Ectopic pregnance Other (specify)	4		23	3d. Date of dela Month	very Day Year
w requires that been signed by should be deta	۵	Part II. Other significant cor	ditions cont	nbuting to death bu	it not result	ing in the ur	nderlying cause giv	ven in Part I.			e contribute to	the cause of death?
n: The law ricate has be	Completed								24a. Was auto perfe 1 \( \text{Yes}	psy ormed?	prior to c death?	topsy findings available ompletion of cause of 2 No
hysi this c	Certification: To Be	3.☐ Suicide 6 ☐ Co	Но	28a. Place of Injur	y Year) 2	R/Outpatien 8b. Time of Injury	28c. Injui Wor M 1	<sup>ner:</sup> 4 □ Nursing F		idence 6 how injury	occurred	ral Route Number,
ospitel or hours efte uneral Dire	cai Cert	29a. Certifier 1 Cert	ifying Physi	building, etc	of my knowl	edge, death	occurred at the til	me, date and place	and due to the	cause(s)	and manner as	stated.
To the Hi within 24 To the Fi completel	Medicai	(Check only 2 ☐ Med one)  29b. Signature and title of ce	ical Examin	er: On the basis of and manner sta	examinatio	n and/or in:	29c. Licens	se number	urred at the time,	29d. Date	signed (Month	to the cause(s)
7		30. Name and address of per ARITO	~	UMSHE	- D		Print) 112-	6 or	erstou	it,	MD	21740
Stat Registra HMH 17 Rev 1/20	ar	APR		32. Registra	ue s	K A	andis.					,

DHMH 17 Rev 1/2001

			For State	State of M	Maryland / Dep		of Health a of Death			0116	10238
			Registrar  1. Decedent's Name (First, Middle, La	st)		rincate	Or Death	2. Date o	Reg. N Death	0.0 0 0	3. Time of Death
	Physici							Month	D	ay Year	1500PM
	/Medic	4.	Harry Eugene Mal  4a. Facility Name (If not institution, giv		r)	4b. City, Tov	m, or Location	ol Death	4	c. County of Death	, , , , ,
	Examili	ei	231 west franklin		,	Hagers				Washingto	nn.
	Funeral		5. Social Security Number 6. S	ex, 7. A	ige (In yrs. last birthday,	If Under 1 Y	ear If Under	24 Hrs. 8. Date of	Birth	9 Birthi	place (State or Foreign
9	Director		215-42-4023	M 2□F	60 Yrs.	Months D	ays Hours	Min. Sept	Day, Year 22 19	45 Mary	land
	g ,		Usual Residence of Decedent		100 City Town and						
	ehov	_	10a. State 10b. County		10c. City, Town or L	ocation					1 ☐ Yes 2 ☐ No
	Ba-f	Director	Maryland Washingto	on	Hagerstow	-					
	death with the Maryland ims 23a or 28a-f ehow r must be notified at	늅	10e. Street and Number 231 West Franklin			10f. Zip Co				citizen of What Cou	ntry?
	s 23	Funerai	11. Marital Status	12. Was Deceden	t Ever in 11 S 12	2174		gin? (Specify Yes o	U.S	14. Race - Ameri	nan Indian
	ther d	L L	1 Never Married 2 Married	Armed Forces	12	If Yes, specify	Cuban, Mexicar	n, Puerto Rican, etc.	140-	Black, White,	
036	urs a	ρ	3 ☐ Widowed 4 ☑ Divorced	1 Tyes 20 If Yes, Give Year or Dates		1 Yes 2	No Specify:			Specify: Wh:	ite
Ŏ	2 ho	Completed	15. Decedent's E		16a. Dece	dent's Usual O	ccupation		16b.	Kind of Business/In	
218	P. ".	pie	(Specify only highest gra	College (1-4o	life.	DO NOT use r	done during mos etired)	t or working			
2	gien gien er th	NO.	11		Roofe	r			Con	struction	1
pu	be filed within 72 hours after tal Hygiene. d other then "natural", or Ite event, the Medical Examine	Be	17. Father's Name (First, Middle, Last,					er's Name (First, Mid			
<u>ya</u>	Meni arke	၉	Clarence Edward N	ſalott			Gold	ie Har	baugh	l .	
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene I Health and Mental Hygiene I Health at I is marked other then "natural", or Items 23a or 28a-f ehow other traumatic event, the Madical Examinar must be notified at		19a. Informant's Name/Relationship (					er or Rural Route Nu			
0	permit. Pages 1 and 3 Department of Health Important: If item 27 eny injury or other tr. once.		Betty Nokes / sis	ster	20b. Place of Disp			t Hagerst			
0	9 = 5		1 Burial 2 Cremation 3		e cemetery, cre	matory or other	r place)			Location - City or To	
Ħ	t. Pa rtmer rtant		4 □ Donation 5 □ Other (Specification 21, Signal resolution 21, S					lar 23 200			
Bal	permit. Pa Departmen Important: eny injury once.		21. Signaura di Funerai Sarvios der	ISA				y Rest Hav			•
			23a Part1 Enter the disease or com	olications that cause						cown mary	Approximate
			23a. Part1. Enter the disease, or com shock, or heart lailure. List only Immediate Cause (Final	one cause on each	line.	/ . i	i dying, sacir as	1	y arrost,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a(	ancer	00/	he	TONG	ul		I year.
	Examiner			Due to (or a	s a consequence of):	0			)		3
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	s a consequence of):				-		
	ansit	Examiner	Securitary list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć.	cate be executed physicien and the burial-transit	Exa	resulting in death) Last	Due to (or a	s a consequence of):						
8760,	cate be ex physicien the buria	dicai		d.							
99	tifica ng ph as th	Med	(5 5 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		_						
Вох	eath certific attending p for use as	an/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		⊒Ectopic pregn	nancy			23d. Date of deliv	•
Э. Е	the at	sici	in the past 12 months? 1  Yes 2 No			Other (specif			_	Month	Day Year
P.O.	that the death ed by the atter detached for	by Physician/Me	9 Unknown								
Vital Records,	89 69	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the t	inderlying caus	e given in Part I		4	use contribute to t	ne cause of death? pably 4 □Unknown
orc	w requir been si should	eted							÷ 185 4	2010 3010	Jabiy 4 Donkhowii
Sec.	has b	Completed						a	Vas an utopsy	24b. Were auto	psy findings available mpletion of cause of
a F	cate pag	S						10 1	erformed?	death?	2 No
Vit.	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor	of Death Check of			
of	Phys this rat dia	<u>1</u>	1 Yes 2 No 27 Manner of Death	1 Linpai			4 LINU			6 ☐Other (Special ury occurred	(v)
n	ding f h. After funer	ion	1⊠Natural 5 ☐ Pending	28a. Date of In (Month, D	ay Year) Injury	M 280.	Injury at Work?		ine now inj	ury occurred	
Division of	Atten deat ctor: y the	fica	3 Suicide 6 Could not b		niury - At home, larm, st				on (Street a	and Number or Rura	al Route Number.
Θ	after Dire	Certification:	4 Homicide determined	building,	njury - At home, larm, st etc. <i>(Specify)</i>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or	Town, Sta	te)	
	spits nours nera / fille		29a. Certifier Certifying Ph	ysician: To the bes	t of my knowledge, dea	th occurred at the	he time, date an	nd place, and due to	the cause(	s) and manner as s	tated.
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Exar	niner: On the basis and manners	of examination and/or instated.	ivestigation, in	my opinion, dea	th occurred at the ti	me, date ar	nd place, and due to	o the cause(s)
	To tl withi To tl	Σ	29b. Signature and title of certifier		1	29c. Li	cense number		29d. D	ate signed (Month,	Day, Year)
			Mall	CN -	10-		0466	+73	Ma	nch 22	, 2006
			30. Name and address of person who	completed cause of	death (Item 23a) (Type	Print)					
05 H	-0		Hind Horme	Jan, M	11); (130	AYO C	L CT	· Hag	enste	am, now	21740
**	Sta	-	31. Date liled (Month, Day, Year)	2006 32. Regis	trar's Signature	1.1.		,			
× 100	Registr	वा		A CONTRACTOR	Echar S.J. Rd	BRAKE					

		•	1 - State of Maryland / Dep	partment of Health and Nertificate of Death		2006	0239
2	Physici /Medic		1. Decedent's Name <i>(First, Middle, Last)</i> <b>J. Ronald Mustard</b>		2. Date of Death Month March 1	Day Year 9 2006	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)  122 Sunbrook Lane	4b. City, Town, or Location of Death Hagerstown		4c. County of Death Washington	
	Funeral Director	8	5. Social Security Number 6. Sex 1½ M 2 F 7. Age (In yrs. last birthda) 78 Yrs.	y If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y June 10	1007	face (State or Foreign try) ginia
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I  Maryland Washington Hag	Location rerstown		1	0d. Inside City Limits  Yas 2 □ No
	with the	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	,
5-0036	hours after death with the Maryland lurel', or Iteme 23a or 28a-f ehow at Exerciser must be collited at	by Funeral	122 Sunbrook Lane  11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. 43 Armed Forces?  1 ☑ Yes ⊆ □ No 7-23-45 [Yes Give Year or Dates: 1-3-46]	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	an Indian, etc.
N-61212	filed within 72 hours Hygiene. ther then "neturel", art, the Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 4	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)  Accountant	king	b. Kind of Business/Inc	
/land /	should be filed nd Mental Hyg marked othe imatic event,	To Be C	17. Father's Name (First, Middle, Last)  Fred M. Mustard	Minn	e (First, Middle, Ma nie Whitak	er	
, Mary	s 1 and 2 sho f Health and h fem 27 is ma other trauma		Erica M. Nelling (friend) 2211	Hudson Road Apt.	1223 Gree	er South Ca	rolina
Baltimore,	0 0		4 Donation 5 Other (Specify) Salisbur	ematory or other place) ry nat'l Cem 3-2	27-06	c. Location - City or To Salisbury	N. Carolin
Ball	permit. Page Department of Important: If eny injury or once.		1) cuicher A Lung	22. Name and Address of Facility Dou 1331 Eastern Blvd.	N. Hagers	town Maryl	and 21742
	Physician /Medical		23a. Fart1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	SPATITY			Approximate finterval Between Onset and Death
,09	icate be executed physician and physician and itemsif	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. CHRUNIC AT Due to (or as a consequence of):  DIABLE S Due to (or as a consequence of):	PIAL FIBRILL MEllitus	ATTON		YEARS JEARS
O. Box 68/60	death certif e attending id for use a	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ory Day Year
2	puires that t n signed by ald be detail	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to the	
Vital Hecords,	rician: The law requires that the scriticate has been signed by th lirector, page 2 should be detache	Completed			24a. Was an autopsy performe	prior to condeath?	psy findings available impletion of cause of 2 No
VITA	ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital:	Othor	th (Check only one)		
Division of	ding Phy h. After this funeral c	ation: To	1 Yes 2 No rospitar: 1 Inpatient 2 ER/Outpati  27. Manner of Death 1 Matural 5 Pending 2 Accident investigation  1 Accident	of 28c. Injury at	ome 5 PAesideno 28d. Describe how		<i>)</i>
DIVIS	tal or Attendirs after death.	Certification:	3 Suicide 6 Could not be determined 28e. Pface of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town,	et and Number or Rura State)	l Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) Medical Examiner: On the best of my knowledge, de Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	rred at the time, date	and place, and due to	the cause(s)
)	with To	M	29b. Signature and title of loarlifier  WIGHT WOOSTEL	29c. License number	3	Date signed (Month, 3 23 0	Cay, Year)
)+	19+1		30. Name and address of person who completed cause of death (Item 23a) (Typ)	Brint) HAGERS 78	WN M	0 2174	2
7	Sta Registi	200	31. Date filed (Month Day, Year) 32. Redistrar's Signature	Inch!			

		State of Maryland / Department / Department / Department / Department / Department / Department			1113 3 2	10010
		Registrar  1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg. 2. Date of Death	No.	3. Time of Death
Physi		Anthony Albert Mitchell		Month March	20 2005	9:03 PM
Exam	dical niner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
n .	B 4 2	13611 Woodland Heights Drive	Hagerstown		Washingto	
Funera Directo		5. Social Security Number  174-16-7096  6. Sex 1X M 2 F  7. Age (In yrs. last birthday)  Yrs.	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, You July 3		nplace (State or Foreign untry)
A TOTAL		174-16-7096 86 Usual Residence of Decedent		outy 3	1919 Pei	nsylvania
nyland how		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
Ba-f s	Director		gerstown			1 ☐ Yes 27 No
death with the Maryland ma 23a or 28a-1 show rmust be notified at	o i	10c. Street and Number	10f. Zip Code	109	. Citizen of What Co	,
na 23	Funerai	13611 Woodland Heights Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13.	21742 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A.	rican Indian,
after or Ite		1 □ Never Married 2 ♥ □ Married   1 ▼ □ Yes 2 □ No 12 − 14 + 44		Hican, etc.)	Black, White	a, etc. Vhite
ZTZ I 3-UU30  within 72 hours after death with the Marylan jiene. r then "natural", or Itema 23a or 28a-f show I'm Medical Examinat must be notified at	d by	3 Wildowed 4 Divorced Year or Dates: 10-20-40	) A ,	1.00		
in 72	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ring	b. Kind of Business/	ndustry
filed within 1 Hygiene.	mo.	Elementary/Secondary (0-12) College (1-4or 5+)	Machinist		Truck Mfg	J•
be filed trai Hygir of other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
	2	Jack Mitchell	Juli;	a Dippazzo	<b></b>	
		Can S S S O Companie	ing Address (Street and Number or Run			21/42
re, n 1 and Health tem 27		Agnes June Mitchell (wife) 13611 20a. Method of Disposition 20b. Place of Dispo	Woodland Heights osition (Name of	Drive Ha	C. Location - City or	Maryland Town, State
Pages lent of nt: If I		1 Surial 2 Cremation 3 Removal from State Cedar La	osition (Name of matory or other place) wwn Mem Park 3-25	5-06 На	agerstown	Maryland
baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 eny injury or other	once.	21 signatur of Funeral Service Licensee 22	2. Name and Address of Facility Dot	uglas A. 1	Fiery Fune	eral Home
n saes	a /	Duiste A Tury 1	331 Eastern Blvd.	N. Hagers	stown, Maj	yland 21742
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failed. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	•	Approximate Interval Between Onset and Death
Physicia /Medica		Immediate Cause (Final disease or condition resulting in death)  Due to (or asy consequence of):	heart gou	lura		
Examine		C 17×144 71	4 costory di	arako		
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	Jane 19 Gr	J Cocse		
<b>6U,</b> be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)				
ficate be executed physician and is the burial-transit	ai E	Due to (or as a consequence of):				
ficate ficate physics the last	edicai	d				
death certific	In/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of del	,
he death	Physician/M		Other (specify)		Month	Day Year
- ± > 0		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
<b>6</b> 8 8	d by	Classic renal imatedio	on M		2 No 3 Pr	
	lete			24a. Was an	24b. Were au	topsy findings available completion of cause of
age h age	Completed			autopsy performe 1 ☐ Yes 2 ☐	d? death? No 1 ☐ Yes	
l VITA! ysician: ' ysician: ' is certifica director, p	Be C	25. Was case referred to medical examiner?	26. Place of Deal	h (Check only one)	(110)	
OT V Physic rthis ca ral dire	ုင	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient			e 6 □Other (Spec	cify)
On OT ding Phys	tion:	27. Manner of Death  28a. Date of Injury  (Month, Day Year)  2	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	injury occurred	
DIVISION OT VITA Il or Attending Physician: after death. Director: After this certific Jin by the funeral director,	fical	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st			et and Number or Ru	ıral Route Number,
s after al Direction	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	otate)	
Hospi 4 hour Funer ely fill		29a. Certifier (Check only (Ch	th occurred at the time, date and place, ivestigation, in my opinion, death occur	and due to the caus	se(s) and manner as and place, and due	stated. to the cause(s)
DIVISIO  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Medical	29b. Signature and this of certifier	29c. License number		. Date signed (Monti	
F3F8		1 Radio Taland M	1) 2006323	3	3-22-200	
		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
5H-6+		Shahid Mahmood MD	, Print) 580 North	iern Au	De Hast	Twon, Md
Regi	State strar	31. Date filed (Month, Day, Year)  NAR 2 3 2006  Agents Signature	rede		S	,

Registrar

and a second

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:50 AM Elizabeth Metcalf 15 03 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sacred Hospital Cumberland Allegany Heart If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, May 12, 5. Social Security Number 6. Sex (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** , 1918 West Virginia 1 □ M 200€ 220-32-4452 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f abov other traumatic event, the Medical Examinar must be notified at WV. Mineral Piedmont 1X Yes 2 No Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 19 Dundee St. 26750 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian within 72 hours after 1 □ Never Married 2 □ Married ☐Yes 30No Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Completed by 3€XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Housework Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie May Swadley Charles Edward Riley SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Smith/daughter HC 64, Box 50, Parsons, West Virginia 26287 laltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of h Importent: If its any injury or ot once. 03/18/ 1 ■ Burial 2 □ Cremation 3 □ Removal from State Keyser, West Virginia Potomac Mem. Gardens 2006 4 ☐ Donation 5 ☐ Other (Specify) permit 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home Was 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 8etween Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronany lears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed anding physician and use as the burial-tran-Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? ò Dav Year 4□Pregnant at time of death P.O. F signed by the a d be deteched for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, cete has been sig , page 2 should b Completed 1 Yes 2 No 3 Probably 4 Minknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 1 Yes 2 2 No ATTAI 1 ☐ Yes 2 ☐ No or Attanding Physicisn: 25. Was case referred to me axaminer? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide Hospital 1/ Dentitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the course(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the Fund (Check only one) the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D21244 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

APR 9 3 2006

			1 - For State Registrar	State of Ma	aryland		artment <i>tificate</i>			ınd M		giene Reg. No.	006	Profession designation	02	lş lş	
	Physici	an	1. Decedent's Name (First, Middle, Las	t)							2. Date of De. Month	ath Day	Ye		3. Time of	Death	
	/Medic		Bettyann Norris								March	23	2006	5	1:15	Рм	
п	Examir	ner											4c. County of Death				
			5. Social Security Number 6. Se		o (la usa la	- A 5 (-45 -4 )	Hag If Under		OWN If Under 2	04 Ure			shing				
	Funeral Director			M 2∑2F	e (In yrs. las	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 09/20/	y, <i>Year)</i> 1922	9.	Country	OH	r Foreign	
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation							10d	I. Inside Ci	ity Limits	
	a-1 sl	tor	MD Washing	ton	Hag	gersto	wn								1 🗌 Yes	2 X No	
	th with the 23a or 28	Funeral Director	10e. Street and Number 17911 Hickory Land	2			10f. Zip	Code 217	40			10g. Citiz	en of What US	Country	/?		
9036	be filed within 72 hours after death with the Maryland nat Hygiene. Id other than "natural", or items 23e or 28e-1 show event, the Micdical Examiner is usally invitiled at		11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		I	Vas Decede Yes, speci		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto i	city Yes or No Rican, etc.)	1	4. Race - A Black, W Specify:	/hite, etc			
Baltimore, Maryland 21215-0036	vithin 72 h ne. han "natu u Medical	Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)			16a. Deced (Give life. L	kind of worl OO NOT use	k doné di e retired)	uring most	of workin	ng	16b. Kin	d of Busine		stry		
22	filed v Hygie other t		17. Father's Name (First, Middle, Last)	T			Home			da Maria	(First, Middle.	A4-1-1- C	Hor	ne		-	
yland	0 = 0 \$	To Be	Fred Richard Snide						Edr	na Ma	ae Tuck	er	,				
, Mar	and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Tonstance S. Crame		er	19b. Mailin 1791	g Address 1 Hic	(Street a Kory	Lane	r or Rura P, Ha	Route Numberstor	wn, City or	Town, State D 217	e, <i>Zip C</i> e 740	ode)		
more	. Pages 1 and 2 should b ment of Health and Ments tant: If item 27 is marked jury or other traumatic e		20a. Method of Disposition  1 ☐ Burial 2X Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify,		сел	ce of Dispos netery, crem .hsbur	natory or oth	ner place			/2006		ation - City asburs				
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licent	800		22	Name and	Address	of Facility	Ger	rald N. eet, Ha	Minr	nich Ì	une	ral H		
8760,	Physician and Medical Examiner is the parial-transit	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	a conseque	nce of):	1.1	of dying	, such as c	eardiac o	r respiratory ar	rest,		In	pproximate terval Betv nset and E	ween	
.O. Box 6	The law requires that the death centificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal d	eath 3 🗌	Ectopic pre Other (spe	gnancy cify)				23	d. Date of o	delivery Da	ay Y	/ear	
rds, P	quires tha in signed I uld be det	by	Part II. Other significant conditions co	ntributing to death b	ut not resulti	ing in the un	derlying ca	use giver	n in Part I.		23e. Did to	bacco use		to the o		leath? Inknown	
Vital Records		Completed									24a. Was a autop perfor	sy	24b. Were prior t death 1 \(\sum Y\)	to compl ?	findings a letion of ca	available ause of	
Vita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hoopital						of Death	(Check only or	ne)					
	die die	lon: To	27. Manner of Death 1 Natural 5 Pending	Hospital: 1 ☐ Inpatie 28a. Date of Injur (Month, Day	y 2	NOutpatient 8b. Time of Injury		c. Injury a	at Nuis	2	ne 5 Resid 8d. Describe h			pecify)			
Division of	il or Attending after death. I Director: After d in by the fune	Certification	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injubulding, etc.	ury - At home. (Specify)	e, farm, stre			es 2□N		8f. Location (S City or Tow	treet and n, State)	Number or	Rural R	oute Numb	ber,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Certifier 1. Certifying Phy cone) 1. Certifying Phy 2. Medical Examination	rsician: To the best of iner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at estigation, i	t the time	, date and nion, death	place, a	nd due to the o	ause(s) a late and p	nd manner lace, and d	as state	od. e cause(s)	1	
	To the within 2 To the complet		29b. Signature and title of certifier				29c.	License	number		2	9d. Date	signed (Mg	nth, Day	v. Year)		
			11	MD			D	006	04	17		31	241	20	06		
ÓН	-4		30. Name and address of person who co Hemen shah,	10 7	eath (Item 2		Print)	m	DV.	Zi	redevi	CIC	MA	2	170)		
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 4 20	32. Registra			este)			<del></del>							

		•	State of Maryland / Department of Health and  1- State Registrar  Certificate of Death		ene 12006	10245
Vario			Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
40	Physicia		Dalton Benjamin Newell, Jr.	March :	Day 2006	12:20 p M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Deal	th	4c. County of Death	1
	LAdiiiii	Çı	13145 Dairymaid Drive #304 Germantown		Montgome	erv
W.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 14 Hrs. Hunder 24 Hrs. Market Park I Under 24 Hrs.			place (State or Foreign intry)
	Director		006-24-4957 1⊠ M 2□ F 75 Yrs. Mortris Days Hours Mill	April 18	3,1930 Mai	
	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	anyla ehov	-	10a. State 10b. County 10c. City, Town or Location			1 ☐ Yes 2x No
	8e-f	ectc	Maryland Montgomery Germantown  10e Street and Number 10f. Zip Code	100	J. Citizen of What Cou	inta/2
	vith ti	급		100		and y r
	s 23g	Funeral Director	13145 Dairymaid Drive #304 20874	Specify Yes or No-	USA 14. Race - Amer	ican Indian.
	er de Item	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Puei	rto Rican, etc.)	Black, White	
36	rs aft	by F	If Yes, Give 1946− 1 ☐ Yes 2 In No Specify:		Specify: Whi	†P
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. dother than "naturel", or Items 23a or 28e-f ehow event. The Madical Examinar most be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation	16	6b. Kind of Business/l	
15	n n	plet	(Specify only highest grade completed)  (Give kind of work done during most of wo life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	orking		
21	d within giene. r than "	Completed	4 Methods Controls Super	rvisor G	eico Insu	irance
Q	e filed within al Hygiene. i other than "	Bec	17. Father's Name (First, Middle, Last)  18. Mother's Na	ame (First, Middle, Ma	aiden Sumame)	
<u>a</u>	should be nd Mental marked c	To E		h Margaret		
Maryland	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 le marked any injury or other traumatic events.		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or F	Rural Route Number, (	City or Town, State, Z	ip Code)
Σ	alth alth 27 l		Betty J. Green Sister 14601 Deerhurst Terrae		Spring, N	
Baltimore,	of He		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	Oc. Location - City or	Town, State
Ë	Page III		1 ⊠Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify)  Gate of Heaven Cemetery Mar	.20.2006 S	ilver Spri	Ing.MD
Ħ	mit. Dartm Dorta / inju		21 Signature of Funeral Service Acensee 2 22. Name and Address of Facility			
ä	P T T S		Francis J. Collins 500 University Blv	runerai H dWSilv	ome, Inc. er Spring,	MD 20901
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.	ac or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final)			Onset and Death
	/Medical		disease or condition resulting in death)  a. Chronic Obstructive Pulmonary Disease to (or as a consequence of):	ase		5 years
	Examiner					
		Je.	Sequentially list conditions, in any, leading to infimediate cause. Enter Underlying Cause (Disease or injury			
	outed id ansit	Examiner	Cause (Disease or injury that initiated events c.			
ó	exec en an rial-tr	EX	resulting in death) Last Due to (or as a consequence of):			
8760,	The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	cal	d			
9	tifica ng ph as th					
Box	eath certific attending p	Physician/Med	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli Month	
	deat	Cla	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
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	es tha igned l	by P	Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
Records,	aquire en si		Coronary Artery Disease, Hypertension,	1 X Yes	s 2□No 3□Pr	obabíy 4 □Unknown
S	aw requis been 2 should	Completed	Aortic Valve Replacement	24a. Was an autopsy		topsy findings available completion of cause of
æ	The lav sete has page 2	E		perform	ed? death?	2 🗆 No
Vital		0	25. Was case referred to medical 26. Place of D	eath (Check only one	**	
$\geq$		To B	examiner? 1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  Other: 4 ☐ Nursing	Home 5 ☑ Resider	nce 6 Other (Spec	cify)
οt			27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work?	28d. Describe how	w injury occurred	
Ö	Attending r death. sctor: After by the fune	atlo	2 Accident investigation M 1 Yes 2 No			
Division	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Ru . State)	ıral Route Number,
ā	telo rsaft al Di ed in	Cer				
	To the Hoepitel or within 24 hours after To the Funeral Direction completely filled in h	cal	29a. Certifier (Check only (Ch	ce, and due to the car curred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	the F in 24 the F the F	Medical	one) and manner stated.			
	. 1	2	29b. Signature and title of centrier 29c. License number	29	ld. Date signed (Mont	ii, Day, Tear)
	12+1		colf Actorby MD D 26540	Ma	rch 16, 20	006
	1		30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)			
			Carl I. Schoenberger, M.D. 16220 Frederick Road #21	3 Gaither	sburg,MD	20877
1	St Regist	ate	31. Date filed (Month, Day, Year)  MAR 2 0 2006			
13.	ricgist	Tai	min a company			

			For State Registrar	State of Ma	aryland				and M	ental Hygi		10016
-	À.	Ġ,	Decedent's Name (First, Middle, Last,							2. Date of Death		3. Time of Death
	Physici		Mary Louise Needha	am					h	Month March 18	Day Year	3:40 P M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Tov	n, or Locatio	laren 10	4c. County of Dea		
			3907 Southview Cou	ırt			J	effers	on		Frede	rick
	Funeral		Social Security Number     6. Security Number	7. Ag		st birthday) 47 Yrs.	If Under 1 Y Months D	ear If Und		8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		, 1958 Was	hington, D.C.								
	and *		Usuel Residence of Decedent  10a, State 10b, County		10c City	Town or Lo	cation					10d. Inside City Limits
	faryla en	Į.		•								1 ☐ Yes 2 🛣 No
	28a-	ect	Maryland Frederic  10e. Street and Number	K	Jei	ferso	n 10f, Zip Co			10	g. Citizen of What C	
	with Sa or		3907 Southview Cou	ırt			101. Zip 00	21755				
	within 72 hours after death with the Maryland ene. Than "naturel", or iteme 23a or 28a-f ehow ha Madical Examiner must be mulified a	Funeral Directo		12. Was Decedent	Ever in U.S	i.   13. \	Was Decedent				United Sta	
മ	or Ites	Fur	1 ☐ Never Married 2XX Married	Armed Forces? 1 ☐ Yes 2 🔯 I	No					cify Yes or No- Rican, etc.)	Black, Whi	
8	rel', c	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 □ Yes 2🔯	No Specia	ity:		Specify:	White
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced	ient's Usuai O	ccupation	ost of workin	1	6b. Kind of Business	/Industry
7	vithin ne. hen.	mpl	Elementary/Secondary (0-12)	College (1-4or 5	5+)		kind of work di DO NOT use re	etired)				
S	filed v Hygie other t		17. Father's Name (First, Middle, Last)	5+		Home	maker	40.44-	Ab - d- NI		Own Home	
_	ntal Had of	Be								(First, Middle, M		
Ë	should be filed within 72 hours after death with the Marylan and Mental Hygiene. Indexted other than "naturel", or Itema 23a or 28a-f show umatic event, the Madical Examiner must be indiffed a	2	William Frederick F			19h Mailin	a Address /St			lores T	elesca City or Town, State,	Zio Codol
Maryland	id 2 s ith an 27 is trau		David Needham / Hu								MD 21755	Zip Code)
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Pla		sition (Name o		March		Oc. Location - City or	Town, State
OL.	ages ant of at: If I		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			crema				rederick,	Maryland
Baltimore,	artmo orter Injur		21. Signature of Funeral Service License	90	1100	22	. Name and A	dress of Fac	cility			
ä	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any Injury or other traumatic evence.		1/1/19		-	Re	sthave	n Fune	ral Se	rvices,	Skkot Cod derick, MI	dy P.A.
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only of	cations that caused	the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Metastat		معامامها	Canaa	-				Onset and Death
	/Medical		resulting in death)	Due to (or as			Gance.					I g years
	Examiner		Sequentially list conditions	)								
	D #	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):						
	and and -trans	каш	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	2 00000000	2000 of).						
760,	ate be executed hysician and the burial-transit	cal E		Due to (or as	a conseque	erice or):						
687	death certificate be executed eattending physician and of for use as the burial-transit											
×	eath certific attending p	Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnance	cv					224 Data of da	15
Вох	atter affor u	clar	in the past 12 months?	1☐Live birth 4☐Pregnant at	2 Fetal c	death 3	Ectopic pregna				23d. Date of de Month	Day Year
o.	by the detached	hysl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown				·				
υ, σ	The law requires that the ate has been signed by thogge 2 should be detached.	by P	Part II. Other significent conditions con	tributing to death be	ut not result	ting in the ur	nderlying cause	given in Par	rt 1.	23e. Did toba	acco use contribute to	o the cause of death?
Records,	w require been sig should b									1 ☐ Yes	2 <b>⊠</b> No 3 □ P	robably 4 Unknown
ပ္တ	aw re	plet								24a. Was an	24b. Were a	utopsy findings available
ř	The lav	Completed								autopsy perform 1 Yes 2	ed? death?	completion of cause of
Division of Vital	tician: T certificat rector, pa	Be	25. Was case referred to medical examiner?					26. Pla	ice of Death	(Check only one		
<u> </u>	Physic this ce al dire	To I	1 ☐ Yes 2 No			R/Outpatien	1 3□ DOA	Other: 4 🗆 I	Nursing Hom	e 5 🖾 Residen	nce 6 □Other (Spe	ocify)
_	or Attending Physician: Itler death. Director: After this certific in by the funeral director.	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 2	28b. Time of Injury	28c. I	njury at Work?		8d. Describe how		
20	death. ctor: A y the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					1 ☐ Yes 2 [				
≥ '	after death Director:	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	. (Specify)	ne, farm, stre	et, factory, off	ice	21	Bt. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
_	To the Hospital of within 24 hours at To the Funeral D completely filled in		29a. Certifier De Certifying Phys	ician. To the hest	of my knowl	ledge death	Occurred at th	o timo, data	and place or	nd due to the ear	use(s) and manner as	
	Hos 24 h Fun etely	Medical	(Check only 2 Medical Examinations)	ner: On the basis of and manner sta	examination	on and/or inv	estigation, in r	ny opinion, d	eath occurre	d at the time, dat	ie and place, and due	s stated.  to the cause(s)
	ompl	Me	29b. Signature and title of certifier				29c. Lic	ense numbe	r	296	d. Date signed (Mont	th, Day, Year)
	, , , ,		Many C	an au	10 F-W		D.	315	86	M:	arch 20, 2	2006
	1		30. Name and address of person who co			23a) (Type, f						
	1		Nancy Dawson, M.D.	22 S. Gr	eene	St. B	altimo	ce, MD	2120	1		
5.5	Sta Registra		31. Date filed (Month, Day, Year) MAR 2 1 201	32. Pegistra	ar's Signatu	k da	aste s					

			1 - State Registrar <mark>Amend Item</mark>	State of Ma	•	•				giene	06	10247	
	Physici		Decedent's Name (First, Middle, L.  Joseph	ast)		nderg			2. Date of Dea Month	Day	Yeer	3. Time of Death	
)	/Medic Examin		4a. Facility Name (If not institution, g.	ive street and number)				or Location of Deat	h	4c. Cour	nty of Death	1,00	
	Examin		SACred Hei	apt HAS	oital	/	Cum	horlar		A	11e GA	anv	
	Funeral Director				(In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		5, <sup>r</sup> f/932	9. Birthp Cour	lace (\$tate or Foreign	
	D .		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	oum or Lo	antion				1	0d. Inside City Limits	
	e Maryla la-f ehov	ctor	MD Alleg	any	Toc. City, 1	Čum	berland				1 XYes 2 □ No		
	n 72 hours after death with the Maryland "natural", or Items 23s or 28s-f show selfes! Exactinat must be notilised at	Completed by Funeral Director	10e. Street and Number 108 Oak Street				10f. Zip Code	21502			itizen of What Country? USA		
		Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Y	Hispanic Origin? (S pan, Mexican, Puer		lace - Americ lack, White,	etc.					
2-003p	ural', c	d by	3  Widowed 4  Divorced	If Yes, Give Year or Dates:	Korean		1 ☐ Yes 2 ☐ No	Specify:			<sup>cify:</sup> whit		
<u> </u>	in 72 t	ojete	15. Decedent's (Specify only highest g	rade completed)		6a. Dece (Give lite.	dent's Usual Occu kind of work done DO NOT use retire	pation during most of wo. ed)	rking	16b. Kind of	Business/Inc	dustry	
717	led within 72 hours after ygjene. ner then "natural", or Ita it, Ita Madical Exemina	Somp	Union Rep./Brake Shoe							Abbex	Corp.		
land	Id be fii ental H ked otl c ever	To Be (	17. Father's Name (First, Middle, Las Michael John I	ne (First, Middle, Catherine	Maiden Sum (Eury)	Pende	ergast						
Mary	nd 2 shoullth and M. 27 Is marl		19a Informant's Name/Relationship Eddy Pen <del>dergas</del> Whitacre	(Type, Print) son		19b Mailie 22 133	otomac	Street	ural Route Number	jerlanč	m, State Zin	රි <sup>න</sup> 21502	
more,	ages 1 and of Heall of Heall to Heall		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		20b. Plac	ardens	Date 3/29/2006	20c. Locatio	n - City or To				
Baltill	permit. Pa Departmen Important: eny injury pnce.		4 Donation 5 Other (Spec			22		elki (FEmilieral I		rland M	D 21500	)	
	46204		23a. Pant Enter the disease, or co	mplications that caused	the death.	Do not ent		rginia Avenu			D 2 1302	Approximate	
١.	Physician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on each lin	re bro		£	accio				Interval Between Onset and Death	
<i>,</i>	/Medical Examiner		disease or condition resulting in death)	a. Due to (or as a			Jiaye	accio	241			four days	
Ļ	¥	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
, ,00/5	ate be executed hysicien and the burial-transit	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last										
200	ficate physics the		1.	d									
	ne death certificate the attending physic the attending physic thed for use as the b	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			Date of delive Month	ory Day Year						
ŗ.	that the object of the object		Part II. Other significant conditions	contributing to death bu	ut not resultir	ng in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?	
ras,	w requires that the de been signed by the should be detached	ed by							1 🗆 Y	′es 2□No	3 □ Prob	ably 4 Denknown	
ပ	2 5 8	Completed							24a. Was autop	an 24	b. Were auto	psy findings available apletion of cause of	
	Thate are	Con							perfo	med? 2 No	death?	2 No	
/Ital	sician: The certificate irector, pag	Be	25. Was case referred to medical examiner?	Manitali			10		ath (Check only o	ne)			
6	9 v =	To	1 Yes 2 No	Hospital: 1 Dippatie		VOutpatier	11 3 1 00A		lome 5 ☐ Resid			v)	
$\subseteq$	en.	atlon	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigati	28a. Date of Injur (Month, Day	Year)	3b. Time o Injury	Wo	iryat ork? ]Yes 2 □No	28d. Describe h	iow injury occ	currea		
DIVISION	al or Atters a after de l'Directo	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At home c. (Specify)	e, farm, str	reet, factory, office		28f. Location (S City or Tox		mber or Rura	l Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examination								
	To the within To the complete	Me	29b. Signature and title of certifler					se number	1	29d. Date sig			
)			1/10	my 2			D3	6766		mari	-42:	4,2006	
	6		30. Name and address of person who					Dive C	. mh		TIM	20218	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra			Land )	-10,000	MI IDO C	UUD	1002	(1300	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 10c, e.f., 11,18, 19a per 1h 8854 4-26-06 vt

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 00:40 02 J. Palman 26 06 Anlene /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) JAN 27, 1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1□M 2 F Months WASHINGTON, DC 215-66-9762 53 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County rthen "naturel", or itams 23a or 28a-f ehow the Medical Examiner must be notified at Gaithersburg 1 ☐Yes 2 No Director MARYLAND MONTGOMERY POCKVILLI 10e. Street and Number 10010 Forest View Place 10g. Citizen of What Country? 10f. Zip Code 20886 10838 ANTICUA TERRACE IISA death v Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. mit. Pages 1 and 2 should be filed within 72 hours after obstment of Health and Mental Hygiene.
octant: If Item 27 is marked other then "naturel", or Itan
toly or other traumatic event. The Medical Examinar Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) EXECUTIVE ASSISTANT BUSINESS 18. Mother's Name (First Middle Maiden Eumame) 17 Father's Name (First Middle Last) Be CARL K. PALMAN ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10838 ANTIGUA TERRACE #102; ROCKVILLE MD 20852 MELISSA LORI PALMAN 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State KING DAVID MEM GARDENS 2/28/2006 FALLS CHURCH, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licenșes any in Myelint. Klobert 11800 NEW HAMPSHIRE AVE; SILVER SPRING MD 20904 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** y eurs Hypertension /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnat 3 Ectopic pregnancy in the past 12 month Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by ate hes been signi page 2 should be Renal 3 Probably 4 Unknown Failure 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? certificate 2 PNo 1 ☐ Yes After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending To the nospinal within 24 hours after death.

To the Funeral Director: Aft 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50718 2-26-06 TonTang, MD oseph 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEORGETOWN ROAD; BETHESDA MD 20814 JOSEPH FONTANA M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 20

2006

32. Registrar's Signature

			1 - For State Registrar	State of N	/laryland /	•		of Health of Death			giene Reg. No. (	006	10249
Е	Physici		Decedent's Name (First, Middle     Kim Elizabet							2. Date of Dea Month 0.3	Day	Year 06	3. Time of Death 23:51 P
	/Medic Examin		4a. Facility Name (If not institution		r)		4b. City, To	own, or Location	of Death	- 00		ounty of Death	
		*	Fort Washingto				Fort If Under 1	Washing Year   If Under		0 D-1(D:4)		ince Ge	
	Funeral Director		5. Social Security Number 218-84-1957	6. Sex 7. A 1 ☐ M 2 ☑ F	Age (In yrs. last l 37	Yrs.		Days Hours	Min.	8. Date of Birth (Month, Day 03 16	, Year)	Cou	place (State or Foreign ntry) D
	ס		Usual Residence of Decedent		140.00					00 10	, 00		
	anyla shov	ក	MD Prince	Georges	10c. City, To		hingto	nn.					10d. Inside City Limits 11√2 Yes 2 ☐ No
	28a-	Director	10e. Street and Number	ccorges	FOLC	was	10f. Zip C				10g. Citize	n of What Cou	niry?
	23a o	al Di	3306 Lumar Driv	<i>r</i> e			20774	4			US	SA	
	tams terms	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	13.	Was Deceder f Yes, specify	nt of Hispanic Or y Cuban, Mexica	rigin? (Spe	ecify Yes or No- Rican, etc.)	14	Race - Americ Black, White,	
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f ehow the Medical Examiner must be notified at	by F	1 ☐ Never Married 2X Marr 3 ☐ Widowed 4 ☐ Divorced	ied 1 ☐ Yes 2 ∑ If Yes, Give Year or Dates			1 ☐ Yes 2 <u>§</u>	No Specify	r:		S	pecify: Bla	ack
21215-0036	72 hou	ted	15. Deceden (Specify only highes		16		dent's Usual (	Occupation done during mos	et of worki	00	16b. Kind	of Business/In	dustry
2	hen "e	Completed	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use	retired)		, ing	D 3:		
Q Q	filed v Hygie Sthart		17. Father's Name (First, Middle,	Last)		Cus	comer	Service 18. Moth		(First, Middle,		imore (	as Co.
<u>lan</u>	Aental Aental rked o	To Be	Carlton Basker	rille				Bre	enda 1	Rolack			
Maryland	2 should and Men is marke raumatic		19a. Informant's Name/Relations	nip (Type, Print)			,	Street and Numb	er or Rura	l Route Numbe		, ,	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at anone.	1	Newton M. Pelt,	III, Husbar				Drive,				MD 207 tion - City or To	
Baltimore,	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S)				sition (Name natory or othe	1	^2 2			ville,	
alti	permit. F Departmi Importar any injur		21. Signature of Funeral Service		1 1	Deak 1 22	e Cren	natory Address of Facil	U3-Z	ickland	Fune	ral Ser	vices
<u> </u>	88 3 2 8		· Erica	Strick	land			lentown			-	gs, MD	20748
П			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caus only one cause on each	line.					r respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or a	as a consequence	10 D	ila	Dan	カーア				
	Examiner		Sequentially list conditions	b	a a consequence	.0 01).							
	pe tisi	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence	e of):							
	al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consequenc	e of):							
8760,	cate be executed physicien and the burial-transit	cal		d									
89 ×	ertifica ling ph	Med	IF FEMALE:	1							T		
Вох	that the death certifice ed by the attending pr detached for use as ti	Physician/Medical	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 ☐ Fetal dea at time of death		Ectopic preg				230	d. Date of delive Month	ery Day Year
P.O.	t the d by the ached	hysl	1 ∐ Yes 2 No 9 □ Unknown	9□ Unknown			S Cirror (open	,/					
S, F	Se US	by	Part II. Other significant condition	ens contributing to death	but not resulting	in the u	nderlying cau	ise given in Part	I.				he cause of death?
ord	w require been si should I	eted								1 U Y			oably 4 □Unknown
Rec	he law e hes l	Completed								24a. Was a autop: perfor	med?	prior to co death?	opsy findings available impletion of cause of
ita		0	25. Was case referred to medical					26. Plac	e of Death	1 ☐ Yes 1 (Check only or	2 No   1e)	1 ☐ Yes	2□ No
>	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		_			ursing Hor	ne 5□Resid	ence 6 [	∃Other (Specil	<b>(y</b> )
uc	ding P	tlon;	27. Manner of Death  1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	ijury 28b Day Year)	Time of Injury	M 28c	lnjury at Work? 1 ☐ Yes 2 ☐		28d. Describe h	ow injury o	occurred	
Division of Vital Records,	or Attending after death. Director: After in by the fune	Certification;	2 Accident investig 3 Suicide 6 Could i 4 Homicide determ	not be 28e. Place of I	njury - At home,	farm, str						Number or Run	al Route Number,
۵	ital or A	Cert	4 - Homeae	Bullaing,	etc. (Specify)					City or Tow	n, Siale)		
	To the Hospital or Attanding Ph within 24 hours after death. The Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier  (Check only one)  Check only 2 Medical	g Physician: To the bes Examiner: On the basis and manner:	of examination a	lge, death and/or in	n occurred at vestigation, in	the time, date a my opinion, de	nd place, a ath occurr	and due to the d ed at the time, o	ause(s) ar late and pl	nd manner as s ace, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. l	License number		ž	29d. Date :	signed (Month,	Day, Year)
•			1	1787dhi	, hy		I.	ンサイー	15		03	-17-	2006
2	(1)		30. Name and address of person Stunt 5 - Gold		death (Item 23a			Class		wo s	Enc	35	
	Sta		31. Date filed (Month, Day, Year)	A2. Regis	trar's Signature			20110	3010	A MI		2)	
47	Registr	ar	MAR 2 0 2	006 Alexan	16	300							

filed within 72 hours after

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic avent once.

Pnysician

/Medical

Examiner

attending for use as

page 2 s

After thi

death.

within 24 hours after death
To the Funstei Director;
completely filled in by the

To the Hospitel or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

THEODORE P. ROSENBERRY

ğ

Completed

Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item#23a 27 28a-f porMF a85/ //25/06 TT

end item#73a 7/ 78a-t perMH 085/14/75/06 11	_
end item#/3a.2/,28a-t_perMF.o854,4/25/06 TT State of Maryland / Department of Health and Mental Hygiene Cortificate of Death	
State of Maryland / Department of Health and Meritar Hygiens	H
Contificate of Dooth	į į

Birthplace (State or Foreign Country)

10d. tnside City Limits 1 Yes 2 □ No

3. Time of Death

2231 P M

		7 - Stata Ragistrar					Cei	rtificat	e of i	Death			Re	g. No.	JU	()
	sician edical	Theodore Paul Rosenberry Jr.										2. Date of Month MARC		Day 24,	20	) 06
	miner										AGERSTOWN OF Death					ďΝ
Fune Direct		5. Social Securi	8-6299	.Sex 1 <b>∑</b> M 2 □ F		e (In yrs. last 35	<i>birthday)</i> Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month, Feb.	Day,		71	9. B
P .		Usual Residence														
ig %	100	10a. State	,													
Many a-f sh		MD Washington Cl					Clear Spring,							6		
the M.	ě	10e. Street and	Number					10f. Zip	Code				10	g. Citize	en of V	Vhat
death with the Maryla me 23a or 28a-f shov	E O	19 W.Cumberland St. 21722								22				U.	S.	Α.
r deat	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S							igin? (Sp	ecify Yes or Rican, etc.)	No-	14	. Rac	e - Ar			

1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:

Specify: white 16b. Kind of Business/Industry

Race - American Indian Black, White, etc.

MD

⁴° WASHINGTON

. Citizen of What Country? U.S.A.

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) <u>12th grade</u> 0

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) driver

1 ☐ Yes 2 No Specify:

trucking company

17. Father's Name (First, Middle, Last) Theodore Paul Rosenberry Sr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
351 S.Cannon Ave Apt 2 Hagerstown, MD 21740

18. Mother's Name (First, Middle, Maiden Surname)

Diana L. Helser

20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

19a. Informant's Name/Relationship (Type, Print)

Triniti Rosenberry

20b. Place of Disposition (Name of cemetery, crematory or other place) March 30 Smithsburg Crematory 2006

Cardiac arrythmia during police restraint

20c. Location - City or Town, State Smithsburg, MD

21. Signal re of Funeral Santa Lion Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. Cardiac arrothmia during police restraint

22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, Inc
P.O.BOX 310 Clear Spring, MD 21722

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

associated with cocaine intoxication Due to (or as a consequence of):

Due to (or as a consequence of)

wife

Due to (or as a consequence of)

IF FEMALE:

Physician/Medical

Š

Be Completed

ို

Medical Certification;

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐ Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably

4 Unknown

24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

✓ Ses 2 □ No

25. Was case referred to medical examiner? 1XXYes 2 □ No 27. Manner of Death

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

2X ER/Outpatient 3□ DOA 28b. Time of Injury March 24, 2006 9:50

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 🗆 Yes 2-X No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

unk 28f. Location (Street and Number or Rural Route Number, City or Town, State) Rt. 40 West,

29a, Certifier

1 Natural

2 Accident

4 T Homicide

3 Suicide

Hagerstown, MD Roadway 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) 25, 2006 MARCH

who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND 21201

State Registrar RUBIO

6 Could not be determined

			For Stata		State of Ma	arylan		artment <i>tificate</i>			lental Hy		000	10051
			Ragistrar  1. Decedent's Name	(First, Middle, La	st)			timouto		- Catri	2. Date of D		- 48 14 LJ	3. Time of Death
	Physici /Medic		HARRY J	OHNSON	RAY, JR.	4					Month March	Da 1		3:50 P M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death											
			Holy Cro  5. Social Security Nur			o (In uro	last birthday)	Sil-		Spring If Under 24 Hrs.	9 Date of B		Montgome	•
	Funeral Director		579.44.26			68	Yrs.		Days	Hours Min.	8. Date of B (Month, D July 1	ay, Year,	937 Wash	place (State or Foreign intry)
	P .		Usual Residence of D			10. 01								
1	arylar •how	ក		Montgom	021		y, Town or Lo							10d. Inside City Limits 1    Yes 2   No
	28a-f	ect	10e. Street and Numb		ery	31.	lver S	10f. Zip C	code			10a. Ci	tizen of What Cou	
	death with the Maryland me 23a or 28a-f ehow finust be notified at	O IE	1401 Blai	ir Mill	Road, Apt	#704			910			_	J.S.A.	,
0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified anonge.	by Funer	11. Marital Status 1  Never Married 3  Widowed 4		12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:		1	Vas Deceder f Yes, specifi I ☐ Yes 2∑		panic Origin? (Sp., Mexican, Puerto Specify:	ecify Yes or N Rican, etc.)	14. Race - Ameri Black, White Specify: B1a	, etc.	
5	72 hou	ted	(Snecifi	5. Decedent's Ed	ducation	16a. Deced	lent's Usual	Occupat	ion uring most of work	ring	16b. K	(ind of Business/Ir	ndustry	
Ž	ithin 79.	mple	Elementary/Second	, , ,	College (1-4or 5	lite. I	DO NOT use	retired)			TT (	0		
7	iled w Hygier Ither ti	Ö	1 Year Lithographic Prin								e (First, Middle	S. Govern	nment	
yland	d be f	o Be			Ray, Sr.					Elizabe			Payne	
<u></u>	shoul nd Me mark	Ě	19a. Informant's Nam		<del></del>		19b. Mailir	g Address (S	Street an	nd Number or Rui	al Route Num	ber, City	or Town, State, Zi	p Code)
Ma Ma	and 2 valth a 27 is		Harriet I	3. Ray/S	ister		1401	Blair	Mil:	1 Rd, #7	04, Si	Lver	Spring,	MD 20910
saltimore,	Pages 1: ment of He ant: if iten ury or oth		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place) Lincoln Memorial Ceme 200. Location - City Suitland,											aryland
Dall	permit. Departimport any in		21. Signature of Fund	eral Service Licer	nsee .		1	. Name and 1800 N	Address lew H	of FacilityHIN Hampshir	ES-RINA e Ave,	ALDI Silv	FUNERAL er Sprin	HOME, INC. ng, MD 20904
			23a. Part1. Enter the shock, or heart	osease, or com failure. List only	plications that caused one cause on each lin	the death	n. Do not ent	er the mode	of dying,	, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)	inal	a Chronic			e Pulm	ionai	ry Disea	se			Unknown
	Examiner			ſ	Due to (or as	a consequ	uence of):							
		Jer	Se wentially list conditions if any, leading to imm	nediate III	b. Due to (or as	a consequ	иелсе от):					<u> </u>		
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Š	icate be executed physicien and s the burial-transit	Ē	resulting in death) La	ist	Due to (or as	a consequ	uence of):							
20/20	cate b	dical			_ d								-	
	The law requires that the death certific He hes been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 Yes 2 1 9 Unknown	onths?	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	Ideath 3□	Ectopic preg Other (spec					23d. Date of deliv Month	very Day Year
Ž.	is that t jned by e detac	by Ph	Part II. Other signific	ant conditions	contributing to death b	ut not resu	ulting in the u	nderlying cau	ise giver	n in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
coras,	equire en sig ould b		Bipolor	Disorder			<del></del>				128	Yes 2	□No 3□Pro	bably 4 Dunknown
l Hecc	The la	Completed	Coronary	Artery	Disease						24a. Wa auto per 1 ☐ Yes	opsy ormed?	death?	opsy findings available ompletion of cause of
l a	cian; ector.	Be	25. Was case referre examiner?	d to medical	Manial					26. Place of Dea	h (Check only	one)		
5	Phys rthis ral dir	P.	1 ☐ Yes 2 ☒ N 27. Manner of Death	0	Hospital: 1 Inpatie		ER/Outpatien 28b. Time of			4 LI Nuising n	ome 5 ☐ Res 28d. Describe		6 □Other (Speci	ify)
0	ding th. : After	tlon	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Inju (Month, Day	Year)	Injury	м	c. Injury a Work? 1 ☐ Ye	es 2 □ No	200. 2000. 20		ny oscanou	
DIVISION	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director After this certifice completely filled in by the funeral director;	Certification;	3 Suicide	6 Could not b determined	e One Place of Init	ury - At ho	ome, farm, str	eet, factory,	office		28f. Location City or To	(Street a	nd Number or Rur e)	ral Route Number,
	e Hospit 24 hours Funere letely fille	edical C	29a. Certifier 1 (Check only 2 one)	Certifying Pr	nysician: To the best niner: On the basis of and manner sta	examinal	wledge, death tion and/or inv	occurred at restigation, in	the time	e, date and place, nion, death occur	and due to the red at the time	cause(s , date an	and manner as s d place, and due t	stated. to the cause(s)
	To the within To the comp	M	29b. Signature and ti	tle of certifier	?				License				ate signed (Month,	
	9		10	70	leeze		70.		-004	5121		Marc	h 14, 20	06
			Brian F.	Reagan,	completed cause of d MD, 1500	Fores	st Gle	n Road	, Si	Llver Sp	ring, M	lary1	and 2091	.0
	Sta Registr	_	31. Date filed (Month		32 Registr	ar's Signa	J. A	entil 1						

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** March 17 2006 12:52 P M Shutt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Airy 6111 Ridgeline Drive Mt. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□M 21XF Vrs April 4, 1944 Pennsylvania Director 010-34-7803 61 Usual Residence of Decedent deeth with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Frederick Mt. Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6111 Ridgeline Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status a filed within 72 hours after I Hygiene. other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: <u>ک</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked othe any liquy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Irene J. Ronan Howard J. Mullaney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mt. Airy, Maryland 21771 Theresa Clark / Daughter 6111 Ridgeline Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 21. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Silver Spring, Maryland Gate of Heaven Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur 1. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon ances **Physician** 3 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ician/Medicai the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☒No Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ፩ ate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No 1 Yes 2⊠ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 🖾 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification; After To the Hospitei or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fune. 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 20s Conflier 1 🕱 Certifying Physician: To the best of my knowledge: death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Chack only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DOOL61661 March, 20,7004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fredisia C. Francis, Fig. 32. Resident's Signature MAR 2 1 2006 7305 Hartwick Road College Park, Maryland 20740 State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year Physician Elizabeth McCormack Sunter ₽₩ 15 2006 7:17 March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🕅 F Yrs. 044-48-9835 86 18, 1920 Scotland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State 10h County or 28a-f show traumatic event, the Medical Examiner must be notified at Anne Arundel Annapolis 1 □Yes 2XXNo Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9211 River Crescent Drive 21401 U.S.A. Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: if Item 27 is marked other than "natural", or Items 23s 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2CXNo Specify: Specify White 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Sloane Reid Jeannie McCormack ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar important: if item 27 is any injury or other trat once. Ronald Sunter/son 7 Saddle Ridge Road New Fairfield, CT 06812 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 3/18/2006 Brentwood, Maryland A □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Symeral Service 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of the death. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician neun one a disease or condition resulting in death) /Medical r as a consequence of): Due to Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last De to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? į 5 Other (specify) 4☐Pregnant at time of death the 9 Unknown à signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 s 1 ☐ Yes 2 No certificate 26. Place of Death (Check only one) director 25. Was case referred to medical examiner Hospital: Other 4 🗌 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 10 1 Tyes 2 1 Nd 1 Tripatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred funeral 28b. Time of 27. Manner Peath Certification: After 5 Pending investigation 1 atural 2 No 1 TYes death. after death. 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide in 24 hours.
the Funeral Dire 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 29d. Date signed, (Month, Day, Year) 29c. License number 29b. Signature litle of certifier 16 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zine de 327 Registrar's Signature 31. Date filed (Month, Day, Year State MAR 1 2006 Registrar

			State of Maryland / Department of H		ental Hyg	giene	
			1 - State Registrar Certificate of	Death	F	leg. No. 0 () 6	10254
	Physici	the an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	ath Day Year	3. Time of Death
	/Medic		HATHORY V. >10an		March	~ 17 200	6 5:38 PM
	Examin	er	university of Many land Medical Center Bat	timore Ci	7	4c. County of Deat	th
墨	Funeral Director		5. Social Security Mumber 234-33-2457 Sex 1XXM 2 F 7. Age (In yrs. last birthday) If Under 1 Year Months Days		8. Pate of Birtl Month, Day APRIL 5,	1986 WEST	hplace (State or Foreign VIRGINIA
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Aaryk Peho	ŏ	WV BERKELEY HEDGESVILLE				1 ☐ Yes 2 🛣 No
	28a-	Director	10e. Street and Number 10f. Zip Code			10g. Citizen of What Co	ountry?
	3a or		5556 HEDGESVILLE ROAD 254	.27		USA	,
	daath ms 2	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H	Hispanic Origin? (Spe	city Yes or No-		
36	itiad within 72 hours attar daath with tha Maryland Hygiana. ther than "naturel", or items 23a or 28a-f ehow int, it a Madical Exambian mant be multified at	by Fur	Armed Forces?  1 Never Married 2 Marned 1 Yes, Give 1 Yes 2 No  3 Widowed 4 Divorced Year or Dates:		Hican, etc.)		e, etc. WHITE
21215-003	72 hours "naturel",		15. Decedent's Education 16a, Decedent's Usual Occur	ipation	-	16b. Kind of Business	Industry
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	be fital hyghed otherwork,	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			
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	s 1 and 2 should I Haalth and Mar Itam 27 is marke other traumatic		19a. Informant's Name/Relationship ( <i>Type, Print</i> ) 19b. Mailing Address ( <i>Street</i> CARRIE SLOAN/MOTHER 5556 HEDGESVILL				zip Code)
Baltimore,	s 1 ar		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other pla	MARCH	ate	20c. Location - City or	Town, State
Ē	Pagas nant of int: if it iry or o		XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  YXBurial 2 □ Cremation 3 □ Removal from State PLEASANT HILL CEMETER	RY 21, 20	006	HEDGESVILLE	, WV
a	parmit. Page Dapartmant important: if eny injury or once.		21. Signature of Funeral Service Licensee 22. Name and Addis	VERA Eª HOME, P		821	
m	<b>8</b> 6 1 2 8		Charles M. Blown 327 W. K	KING ST., MAR	RTINSBURG	, WV 25402	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyill shock, or heart failure. List only one cause on each line.	ing, such as cardiac o	or respirato ar	rest,	Approximate Interval Between
Ø.	Physician		Immediate Cause (Final disease or condition		N		Omset and Death
-	/Medical Examiner		resulting in death)  Due to (or as a considerance of):		/	/	34.63
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	nsit		cause. Enter Underlying	1//	MEDICAL E	(M)	
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Вох	daath certifi e attanding I id for usa as	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnance	cy		23d. Date of de	111.
0.	0 00	Physician/Me	1			Month	Day Year
۵.	that the de lad by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause go	iven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
Division of Vital Records,	Tha law raquiras that tha sta has baan signad by th baga 2 should ba detacha	ed by			1 🗆 Y	/es 2 → 3 □ Pi	robably 4 Unknown
000	awra 1s bag 2 sho	piet			24a. Was	an 24b. Were a	utopsy findings available
ž		Completed			autop perfor	rme@2? death?	completion of cause of : 2 □ No
/ita	Attending Physician: r daath. ector: Aftar this cartifics by the funaral director, 6	Be (	25. Was case referred to medical exarbiner?	26. Place of Death	(Check only o	ne)	
of \	Physic this o	P	122 En Outpatient 3 DOA			dence 6 Other (Spe	cify)
ח	ding Phy h. Aftar thi funaral	Certification:	Talada Salada Sa	ork?	28d. Describe r	now injury occurred	0-1
S	daatt daatt ctor: / tha	cat	3 Suicide 6 Could not be	Yes 2 H	IVIDTOS	Vehicle Street and Number of B	Clash
<u>&gt;</u>	i or Attendati after daati Director:	erti	4 Homicide determined building, etc. (Specify)	'	City or Toy	Street and Number of R	MEDGESVICLE,
	Hospita 14 hours Funeral taly fillac	ai	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the tr	time, date and place,	and due to the	cause(s) and manner as	
	To the Hospital or At within 24 hours after or to the Funeral Directomplataly fillad in by	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my one) and mapner stated.	opinion, death occurre	ed at the time,	date and place, and due	e to the cause(s)
	To the within 2 To the complat	ž	29b. Signature and title of certifier 29c. Licens	nse number		29d. Date signed (Mont	h, Day, Year)
•			Hay Houres	-19797		Murch 18,	2006
7.	1 11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Timothy Novosci MP 22 South G  31. Date filed (Month, Day, Year).  32. Degistrar's Signature	1.	211	1/-	2/201
21	4-4		31 Date filed (Month Day Year) 32 Photostrar's Signature	IREAR ST.	134/1.	note, My	21201
100	Sta Registi		31. Date filed (Month, Day, Year). 32. Registrar's Signature				

			State of Manuard / Der	partment of Health and M	-	_	
		•	4 (0)	ertificate of Death		. No. A A A	10255
-	A. L.	ş	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Phillip Snodderly		March	18 2006	3: 12 AM
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
	- 40.0°	5	Mivesity of Maryland Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda	Baltimure v) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimo 9. Birthol	
2	Funeral Director		216-38-0548 1™ 2□F 64 Yrs.	Months Days Hours Min.	Month, Day, Y June 12	1941 Mary	ace (State or Foreign try) Land
	pu »		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			Od. Inside City Limits
	Aaryla February	ō					1 ☐ Yes 2X No
	r 28e-	rect	Maryland Washington Hage  10e. Street and Number	rstown 10f. Zip Code	10g	. Citizen of What Coun	try?
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	r dea	Iner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> </ol>	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, 6	an Indian,
36	rs afte	by Funeral Director	1 □ Never Married 2 Married 1 □ Yes 2 No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 🛣 No Specify:		Specify: Whi	ite
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28e-f ehow the Medical Exemples must be notified at	ted t	15 Decedent's Education 16a Dec	cedent's Usual Occupation	. 16	6b. Kind of Business/Inc	lustry
215	thin 7.	Completed	(Specify only highest grade completed) (Girl Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work DO NOT use retired)	ng		
	led will ygien ther the	Con	12. D	irector of Plant Op	erations (First, Middle, Ma	Community	/ College
Maryland	ntal H	Be	Sherman E. Snodderly				
Z	shoulk nd Me mark imati	ဥ	The state of the s	iling Address (Street and Number or Rura	yn Baech al Route Number, C		Code)
	alth a alth a 27 io		Cheryl Ann Snodderly (wife) 12	950 Beck Road Hager	stown Mar	ryland 2174	12
Baltimore,	of He of He if itam or oth		20a. Method of Disposition  1 Normal 2 Ocemation 3 Demoval from State  20b. Place of Discometery, circles	position (Name of rematory or other place)	Date 20	c. Location - City or To	wn, State
Ë	tment tant:		4 Donation 5 Other (Specify) ROSE H1	11 Cemetery 3-22		agerstown M	4
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 23 or 28e-1 ehow emportant: if item 27 ie marked other then "naturel", or items 23a or 28e-1 ehow emportant: in Item 25a or 28e-1 ehow emportant in Item 25a or 28e-1 ehow emportant in Item 25a or 25a-1 ehow emportant in Item 25a or 25a or 25a ehow emportant in Item 25a ehow		1	22. Name and Address of Facility Dou 1331 Eastern Blvd.	-	-	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
8	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Acute myelerene	us /eukemia			Offset and Death
	Examiner		Due to (or as a consequence of):	Su James			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Syparome			
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events c				
760,	te be execut ysiclan and e burial-trar	cal E	Due to (or as a consequence or):				
687	certificate nding phys use as the		d				
Вох	th cert endin	an/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	B⊟Ectopic pregnancy		23d. Date of delive	•
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med		5 Other (specify)		Month	Day Year
P.O.	that the	, Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
Vital Records,	w requires that the been signed by th should be detache	d by			1 ☐ Yes	2 No 3 Prob	ably 4 Unknown
000		Completed			24a. Was an	24b. Were auto	osy findings available
<u>m</u>	The te h	Com			autopsy performe	ed? death? ZNo 1 ☐ Yes	
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		h (Check only one)		
of	o o	To.	1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpat  27. Mannayof Death 28a. Date of Injury 28b. Time		me 5 Residen	ce 6 Other (Specify	")
on	Attending r death. ector: After by the fune	tlon	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation		25d. Doscribo now	, injury localities	
Division of	Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rura	l Route Number,
Ö	itel or irs aftr rei Dir lled in	Cer					
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, date	ise(s) and manner as st e and place, and due to	ated. the cause(s)
	vithin somple	Med	29b. Signature and this of cartifier	29c. License number	290	d. Date signed (Month,	Day, Year)
	. , , , ,		MD	P 17667	1	Unch 18,	2006
	11		30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	110	2:21	
9	H-10		31. Date filed (Month, Day, Year)  32. Registrar's Signature	e Street, Baltimur	E, MD.	2/201	
1	Sta Regist		MAR 2 1 2006 A	loude			

3 w 5	W.	1 - For State Registra MEND#24a peri			-			Death		2. Date of De	Reg. Ne		6	0256
Physic /Med		MABLE W. SOPER	,	4						Month MARCH 7	Day	6	Year	10:45 A M
Exami		4a. Facility Name (If not institution, gir	e street and numbe	r)		4b. City	, Town, or	Location of	of Death		4c.	County	of Death	
	- A	13351 TRIADELPHIA MI					ARKSVI		2411			OWARD		
Funeral Director		578-07-6646	Sex 7.7 1 ☐ M 2 💢 F	Nge (In yrs. 94	last birthday) Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Di 10/10/1	rth ay, Year) .911		Coun	lace (State or Foreigr try) VIRGINIA
and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside City Limits
Marylan -f ahow	ţō	MARYLAND HOWARD		C	LARKSVII	LE								1 ☐ Yes 2 📉 No
or 28e	Director	10e. Street and Number					ip Code				-		hat Coun	try?
ath w	ral	13351 TRIADELPHIA MI					1029					SA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28e-f ahow many jury or other traumatic avant, tra Medical Exam or must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Deceder Armed Forces 1  Yes 2  If Yes, Give Year or Dates	s? ] No	1			ispanic Ori in, Mexican Specify:		cify Yes or No Rican, etc.)	0-		k, White,	an Indian, etc. ITE
2 hou	ted	15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occupa	ation	. , .		16b. K	ind of Bu	siness/Inc	
d 2 should be filed within 72 hours af th and Mental Hyglene. ?? Is marked other than "natural", or traumatic event, the Medical Exem	Completed	(Specify only highest gr Elementary/Secondary (0-12) 12	a <i>de completed)</i> College (1-4o	r 5+)	life.	DO NOT	use retired	during mosi i)	t of workir	ng	OLI	IN TIOM	TC.	
filed v Hygie other t		17. Father's Name (First, Middle, Las.	· · · · · · · · · · · · · · · · · · ·		HOME	MAKE	K	18. Mothe	ar's Name	(First, Middle		N HOM		
id be ental ked o	To Be	DANIEL HOUSTON (	COOK							. E. DED			,	
shou and M s mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addres	s (Street a	and Numbe	er or Rura	l Route Numb	per, City o	r Town,	State, Zip	Code)
and 2 salth a n 27 l		ETHELWYN SOPER - DA	UGHTER		77 CH	ERRYT	REE CI	RCLE;	LIVER	POOL NY	13090			
permit. Pages 1 ar Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation 3	Removal from Stat		Place of Dispo cemetery, crea	osition (Na matory or	ime of other plac	e)	D	ate	20c. Lo	ocation -	City or To	wn, State
rtmen rtmnt: njury		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	**	CE	DAR HILL				3/13/			TLAND	<i>'</i>	
permil Depar Impor any in			Color							ES-RINAL ; SILVER				
Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	line.	th. Do not en						arrest,			Approximate Interval Between Onset and Death
te be executed ysicien and re burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a Due to (or a d.		,									
ath certil attending for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🍘 No 9 ☐ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Feta	al death 3	Ectopic i	pecify)					23d. Date Mor	of delive	ry Day Year
w requires that the debeen signed by the should be detached		Part II. Other significant conditions		but not res	sulting in the u	nderlying	cause give	en in Part I.		}	tobacco u			e cause of death?
he law requires to the law requires to the lass been signed by the last been signed by the last last last last last last last last	Completed	USTROPO								24a. Was	an	24b. W	Vere autor	osy findings available
	e Co	25. Was case reterred to medical								1 Tes	2 No		☐ Yes	2□ No
Physician: The Is this certificate har ral director, page 2	To B	examiner?  1 Yes 2 No	Hospital:	tient 2	ER/Outpatier	nt 3□ D	OA Othe	257		(Check only		6 □Othe	r (Specifi	<i>(</i> )
ding After fune		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of In (Month, D	jury	28b. Time o Injury		28c. Injury Work		2	28d. Describe				7
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined		njury - At h etc. <i>(Speci</i>	ome, farm, sto fy)	reet, facto	ry, office		2	28f. Location ( City or To			or Or Rura	l Route Number,
To the Hospital or within 24 hours afte to the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manner	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	ne, date an pinion, dea	d place, a	and due to the ad at the time,	cause(s) date and	and mar d place, a	ner as st nd due to	ated. the cause(s)
To th within To th compl	Me	29b. Signature and title of certifier	11.				c. License					-		Day, Year)
But		1 20/50	lle				725	94	7	ins	my	2014	7,	2006
		30. Name and address of person who	completed cause of	death (Iter	7 23a) (Type,	Print)	en.	ins	MINI	List	mo	w	1019	•
St Regist	ate	31. Date filed (Month, Day, Year)		trar's Signa	ature	was "		1 / - 0				-		

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 1913 **Physician** 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Rockville If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 3 / 21 / 1928 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 → M 2 □ F **Funeral** Months 215-33-3436 Director Palestine Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if them 27 is marked other than "netural", or items 23a or 28a-f ehow my joing other traumatic event, the Madical Examinar must be notified at one. Montgomery Clarksburg 1 ☐ Yes 2 No Md. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11908 20871 Jordan Piedmont Rd. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unemployed none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ali Swaid Amina Nahawi ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11908 Piedmont Rd., Clarksburg, Md. 20871 Ghassan Swaid/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Maryland National 3/18/06 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary 21. Signature of Funeral Service Licensee 064 411 Kennedy St., N.W. Washington, DC 2001 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPTIC SHOCK Physician 7014 /Medical Due to (or as a consequence of): 7 DAYS Examiner CELLUITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan this certificate has 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1, Sun patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4 - Homicide 23s Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the nause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Dre. sugh 30112 MARCH 17 2000 GUTICAL COPILE CONSCITANT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UILEWOLA K SAKEWA MD, 12(0) STAN ORIFT DR. GERMANTUWN MU 20876 31. Date filed (Month, Day, Year) MAR 2 0 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarMFND#23a(b)perMD3/20/06,BMW,MbCo Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 Lynn March 4:30 Amv Shiver  $a^{M}$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | March 6, I 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1 □ M 2 🗙 F 51 Yrs. 1955 Washington, DC Director 216-68-2023 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1⊠Yes 2□No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a 10401 Grosvenor Place Apt. 425 20814 United States Pages 1 and 2 should be filed within 72 hours after death inent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 DYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Caucasian Completed by 3 ☐ Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Worker Human Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rhonda Woronoff Everett Simon, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 St. Lawrence Drive; Silver Spring, MD 20901 Ian Shiver / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Depertment of H Important: If Ita any Injury or ot once: 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 3/16/2006 Brentwood, Maryland 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center
1040 Rockville Pike; Rockville, Maryland 20852 23a. Part 1. Enjer the disease, or com shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Immediate Cause (Final disease or condition Pnysician CALOTO PULMYNY MAS resulting in death) /Medical Due to (or as a consequence of): SEPSIS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ SUSAME Lupus CMY THROMATUSTS 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate hes 1 Yes 2 2 No or Attanding Physician: : After this certifical funeral director, I 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 hpatient Medical Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manney of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Pratural 5 Pending death. 1 Tyes 2 □No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funarel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of Certifier 29d. Date signed (Month, Dey, Year) MD00052774 2006 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001 SUBMIN BUSHIM

MO

32 Registrar's Signature

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2006

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MAR 20

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	14 111011141	Reg. No. 0 0 (	5 10259
			1. Decedent's Name (First, Middle, Last)	2. Dete of D Month		3. Time of Death
	Physicia		John V. Sears Jr.	3	11 200	6 5:05 A.M
)	/Medic Examin	_	46 Fecility Neme (if not institution, give street end fromber)	n, or Location of Dea		
			bacted neare nobprear	erland	Alleg	any  Birthplace (State or Foreign
	°Funeral Director		218-64-8918 1XM 2LIF 51 Yrs.	Min. 8 – 2	9 – 1954	Country) WV
	pu k		Usuel Residence of Decedent  10a, Stete 10b, County 10c, City, Town or Location			10d. Inside City Limits
	Aaryle f sho	6	MD Allegany Westernport			1 X Yes 2 □ No
	158 the	Funeral Director	10e. Street end Number 10f. Zip Code		10g. Citizen of Who	et Country?
	3a or		112 Kelly AV. 21562		USA	
	death	ē	11. Maritel Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Original In Yes, specify Cuben, Mexican,	in? (Specify Yes or I Puerto Rican, etc.)	No- 14. Race - Black,	American Indian, White, etc.
Baltimore, Maryland 21215-0020	iges 1 and 2 should be filed within 72 hours after death with the Manyland it of Heelih and Mental Hygiene. It if item 27 is merked other than "natural", or terms 23a or 28e-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Merried 1 Yes 2 No If Yes, Give 1 Yes, Give Year or Detes:		Specify:	White
5-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)  16e. Decedent's Usual Occupation (Give kind of work done during most of the completed)  (Give kind of work done during most of the completed)	of working	16b. Kind of Busi	ness/industry
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2	lygier Ner th	S	12 4 Self Employed 17. Father's Neme (First, Middle, Last) 18. Mother	's Name (First, Midd	fle, Maiden Surname)	
anc	De fi	Be	17. Faller's North (1 113), Milder, 2237	y E. Far		
Ž	d Mei d Mei merk metic	မ	John V. Sears Sr. Mar'  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number			tate, Zip Code)
Σ	trau	_1		st. Pied	mont. WV	26750
ē,	tem ?		20a. Method of Disposition (20b. Place of Disposition (Arabic of Dis	Date	20c. Location - C	ity or Town, State
E O	Page ent o rt: if i		1 G Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	ıs 3 <u>-</u> 15-	06 Keyse	r, WV.
att	permit. Pages 1 and 2 Department of Heelth e Important: if item 27 is any injury or other tra		21. Signeture of Funeral Service Line 1999 22. Name and Address of Facility	Fredloc	k Funera	1 Home
Ö	Depa impo any i	- 1	illediam Alexander Alexander 31 Jones ST.	Piedmon	t, WV 2	6750
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  e. Alcoholic circhesis with	decom	persation	1
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	d d ansit	edical Examiner	b			
ó	tificete be executed ig physician and es the bunal-transit	Exa	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying			
68760,	ate be nysicia he bu	lcal	Ceuse (Disease or injury that initiated events presulting in death) Last Due to (or es e consequence of):			
	artifice ing ph e es t	-	d			
Вох	The law requires that the deeth cent ete hes been signed by the attendiny page 2 should be deteched for use	Physician/N		l act =		with the the course of death?
<u>.</u>	res that the de signed by the a be deteched t	ysic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ribute to the cause of death?  3 Probably 4 Unknown
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of Vital Records,	sign id be	d by		24a. W	/as en autopsy erformed?	24b. Were autopsy findings available prior to
õ	v require been sign	jete		_		completion of cause of death?
æ	he law e hes age 2	Completed		1	☐ Yes 2 PNo	1 ☐ Yes 2 ☐ No
tal	ician: The certificate rector, pag	BeC	25. 1183 0030 10101104 10 111001041	of Deeth (Check or	ly one)	
<u>=</u>	Physician: this certific rel director,	ToB	TEMPARATE ELECTION		esidence 6 Dothe	
0 0	ding Phys h. After this funerei d		27. Menner of Deeth  1 Contained 5 Pending (Month, Dey Year)  28b. Time of Injury at Work?  1 Contained 1 Pending (Month, Dey Year)  M 1 1 Yes 2 1		be how injury occurre	od
Division	Attending in death.	cat	2 Accident  3 Suicide 6 Could not be	28f. Locatio	on (Street and Number	er or Rural Route Number,
$\overline{S}$	or Al efter Direct I in by	ertif	4 Homicide determined building, etc. (Specify)	City or	Town, State)	
_	To the Hospital or Attending Physician: The Is within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical Certification:	29a. Certifier  (Check only  Certifying Physician: To the best of my knowledge, deeth occurred at the time, date en (Check only)  [Certifying Physician: To the basis of examination and/or investigation, in my opinion, deal end proper stated.]	d plece, and due to th occurred et the tir	the ceuse(s) and mar ne, date and place, e	nner as stated. nd due to the cause(s)
	thin 2 the the t	Med	one) end manner steted.  29b. Signature and title of certifier 29c. License number		29d. Date signed	(Month, Day, Year)
	F \$ P 8	_	95000	7	3/14/	106
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 1	100 01503
	12		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Hwam Semum, m.D. SACRED HEART (Hosp  31. Date filed (Month, Day, Year)  32. Registrer's Signature	tol Cum	buland	MU 11302
	St	ate	31. Date filed (Month, Day, Year) 32. Registrer's Signature			
	Regist		MAR 1 6 2000			

			For Stete Registrar		State of	f Marylar	•	artment of H		ind M		iene	06	10260
	Physici	an	1. Decedent's Name (First, Mid		TD.						2. Date of Deat Month	Day 15	Year	3. Time of Death
	/Medic	al	CLEM O. SMI:  4a. Facility Name (If not instituti			n her)		4b. City, Town, or	1 ocation o		MARCH	_	2006 unty of Death	1:25PM <sup>M</sup>
	Examin	er	CANDLE LIGHT	_		11007/		EAS		, Dogar				LBOT
	Funeral		5. Social Security Number	6. Sex		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. Min.	8. Date of Birth (Month, Day, MAR 25	Year)		place (State or Foreign
	Director		347-10-7471	1 🗷	M 2□F	87	Yrs.	Months Days	ricurs	IVIII.	MAR 25	1918	IND	ÏÁNA
	land		Usual Residence of Decedent  10a. State 10b. Coun	у		10c. Ci	ty, Town or Lo	ocation	-				1	10d. Inside City Limits
	Mary -f sh	to	MD TA	LBOI			EAST	ON						1 ¥Yes 2 □ No
	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28e-f show fra Maulcal Exterili et mail be maillied at	Funeral Director	10e. Street and Number			***************************************		10f. Zip Code			1	0g. Citizer	of What Cou	ntry?
	23a c	rai	106 W. EARLE	AVE.					601				USA	
	er deg	nue	11. Marital Status		Armed Fo		J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Orig in, Mexican	gin? (Spe , Puerto l	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
36	irs aft	by F	1 Never Married 2 Married		1 Types If Yes, Giv Year or Da	e e		1 ☐ Yes 2 🛣 No	Specify:			Sp	ecify: WHI	re
21215-003	2 hou	ted	15. Decede	nt's Educ	ation		16a. Dece	dent's Usual Occupa	ation	of worki		16b. Kind	of Business/In	dustry
215	thin 7	Completed	(Specify only high Elementary/Secondary (0-12)		College (1	-4or 5+)	life.	DO NOT use retired	l)	OF WORK	rig			
	filed wi Hygien other th		12	( = =4)	<del>5+</del>	-	ACC	DUNTANT	10 Matha	do Novo	/Final Middle A		ERN ELI	ECTRIC
aryland	uld be fi dental H rked otl tic ever	Be	17. Father's Name (First, Middle CLEM O. SMITT								(First, Middle, N	viaiden Sui	mame)	
2	should nd Men marke	은	19a. Informant's Name/Relation				19b. Mailir	ng Address (Street a			AKEMAN  I Route Number	City or To	wn, State, Zig	Code)
≥	1 and 2 s Health ar em 27 is		DAVID H. SMIT				209	GOLDSBOR	OUGH :	ST.,	EASTON,	MD :	21601	,
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel; or items 23a or 28e-f show any injury or other treumatic event, the Modical Extering read to notified at ance.		20a. Method of Disposition  1 Burial 2 Cremation	2 DB	amount from		Place of Dispo cemetery, crei	sition (Name of matory or other plac	e)	D	)ate :	20c. Locat	ion - City or To	own, State
Ĕ	Pages ment of l ent: If its ury or o		'4 □Donation 5 □Other		emoval irons .	AS	HE LAW	MEM. GA	RDENS	3/2	0/2006	JEFF.	ERSON,	NC
Ball	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service	e License			, FI	2. Name and Addres	ELFEN	BEIN	& NEWNA	M FU	NERAL I	HOME PA
	40740		23a. Part1. Enter the disease,	Z.		LCER:	20 کے	00 S. HARI	RISON	ST	EASTON,	MD 2	1601	Approximate
ı			shock, or heart failure. Li Immediate Cause (Final	st only on	e cause on e	ach line.		1		1	i respiratory arre	391,		Interval Between Onset and Death
	Ph <del>ysician</del> /Medical	î l	disease or condition resulting in death)	a	· _ Pue to (	or as a consec	ilance of:	Cente	urc		•		-	3 grs
	Examiner					01 43 4 0011301	quarioo 01).							ð.
	D #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>J</b> <sup>b</sup>		or as a consec	quence of):							
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
760,	ate be executed thysician and the burial-transit	ai E		ł	Due to (	or as a consec	quence di).							
687	The law requires that the death certificate be executed ste has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edicai		d										
Box	that the death certifice ed by the attending pl detachad for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23		come of pregn		75				23d	. Date of delive	ery
	death	sicia	in the past 12 months? 1 Yes 2 No			inth 2 ☐ Feta ant at time of c		∃Ectopic pregnancy ∃ Other <i>(specify)</i>					Month	Day Year
Р. О.	at the	Phys	9 Unknown								00 01111			
	signed by det	by	Part II. Other significant condi	au k	tributing to de	ath but not res	sulting in the u	nderlying cause give	en in Part I.			acco use s 2□N	/	he cause of death?
Š	v requir been si should	etec			-/	•					100			
Records,	has a	Completed									24a. Was a autops perform	y	prior to co death?	psy findings available mpletion of cause of
	ician: Th certificate rector, pag	e Co	25. Was case referred to medic	al					26 Place	of Death	1 Yes 2	2 No	1 🗌 Yes	2□ No
>	ysicia is cert direct	O B	examiner? 1 Yes 2 No		ospital:	npatient 2	ER/Outpatier	nt 3 DOA Othe			ne 5 ☐ Reside		Other (Specif	ASSISTED
פר	Attending Physician: or death. sector: After this certified by the funeral director, I	n: T	27. Manner of Death  1 Natural 5 Pend	lina	28a. Date of	of Injury th, Day Year)	28b. Time o		/ at		28d. Describe ho			LIVING
Sio	endir eath. or: Af he fur	catic	2 Accident inves	tigation	,			M 1	Yes 2 1	No				
Division of Vital	I or Attending after death. Director: After I in by the funer	Certification:		mined	28e. Place buildir	of Injury - At h ng, etc. (Speci	nome, farm, sti ify)	reet, factory, office		1	28f. Location (St. City or Town	reet and N n, State)	lumber or Rura	al Route Number,
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funerel Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certify	ina Phys	ician: To the	best of my kni	owledge deat	h occurred at the tim	ne, date an	d place s	and due to the co	ause(s) and	d manner as e	tated
	e Hos	edicai	(Check only 2 Medical	I Examir	er: On the ba	asis of examination	ation and/or in	vestigation, in my of	pinion, deal	th occurre	ed at the time, da	ate and pla	ice, and due to	the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certif	ier _				29c. License	e number				igned (Month,	Day, Year)
)	١		> Durit	On	Why			103	1887	)	3	115	106-	
1,2	T/4)		30. Name and address of person			,		*	1					
~	עונדיי					66 PIN's egistrar's Sign		RIVE, EAST	ron, M	4D 21	1601			
	Sta Registr		31. Date filed (Month, Day, Yea	6 200	400	Bore .								

		For State		State	of M	larylan		artment of H		Mental Hy	giene	E'h alli	
		Registrar					Ce	rtificate of L	Jeath	L a D 11 -1 D	Reg. No.	46	10262
Physicia	_	1. Decedent's Name Fra	, ,	de Tho:	mpsc	on				2. Date of De Month March	Day	6 Year	3. Time of Death 1:05 A M
/Medica Examine		4a. Facility Name (I					170	4b. City, Town, or TOWS		h		y of Death	re
		5. Social Security N		6. Sex			ast birthday		If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign
Funeral Director		213-28-	9409	1 <b>½</b> M 2□	F	87	Yrs.	Months Days	Hours Min.	Dec. 25	, 1918	Wes	t Virginia
pus *	-	Usual Residence of 10a. State	10b. County			10c. City	r. Town or L	ocation					Od. Inside City Limits
with the Maryland or 28a-f ahow	20	MD	Balti	more			Parkt	on					1 ☐ Yes 2 X No
28a-	Director	10e. Street and Nu	mber					10f. Zip Code			10g. Citizen of	What Cou	ntry?
		16912	Mille	r Lane				21120		_	U	.S.A.	
	Funeral	11. Marital Status		12. Was I	Decedent d Forces	Ever in U.	S. 13	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S	pecify Yes or No	)- 14. Ra	ce - Ameri	
lis a	þ	1 ☐ Never Marr 3 ☐ Widowed	112	ed 1 ☐ Y	es 2.0 Give or Dates:	No		1 ☐ Yes 2X No	Specify:	o nican, etc.)	Spec	ack, White, ify: <b>W</b> }	nite .
72 ho	ted	(Spec	15. Decedent	's Education	ed)		16a. Dec	edent's Usual Occupa	ation Jurina most of war	rkina	16b. Kind of	Business/In	dustry
d within 7 gene. Ir than "	Completed	Elementary/Seco		Ť	ge (1-4or	5+)		e kind of work done of DO NOT use retired			Chaol.	M.C.,	
e filed within al Hygiene. I other then vent, the Me	ပ္ပ	17. Father's Name	(Circt Middle	( act)			Opera	tor - Hea	18. Mother's Nar		Steel		
d be filed nial Hyg ed other	Be			ompson						ie Alle		,,,,,	
should ind Men s marke umatic	၉	19a. Informant's N					19b. Mai	ling Address (Street a				n, State, Zip	Code)
and 2 sealth ar n 27 is	9	Donna	E. The	ompson	/Wif	e	16	912 Mill	er Lane	e, Park	ton, I	MD 21	120
permit. Pages 1 and 2 should be Department of Health and Merial Important: If item 27 is marked of any injury or other traumatic ava 2008.	Ü,			3 □Removal fi	om State	20b. P	lace of Dispendence o	osition (Name of ematory or other place frove Uni st Cemeter	ted Marc	ch 30,	20c. Location	•	
permit. Departm Importal any inju		21. Signatura PF	1		Lu	u <sup>^</sup>	1 4	22. Name and Address 24 Secon	s of Facility J	.J. Hart			tuary,Inc. 17349
		23a. Part Enlert	the disease, or	complications th	nat cause	d the death	n. Do not e	nter the mode of dyin-	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause disease or condition	(Final	only one cause			nt;			(			Onset and Death
/Medical		resulting in death)	on	a	_	s a consequ		F9					
Examiner		Sequentially list co	onditions	b. ———									
si ed	iner	if any, leading to in cause. Enter Under Cause (Disagree)	mmediate erlying	Due	to (or a	s a consequ	uence of):						
be executed ician and burial-transit	Examiner	that initiated events resulting in death)	S	c	to (or a	s a consequ	uence of):					-	
bur bur	dical E												
= 0.8	Φ.												
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Completed by Physician/M	IF FEMALE: 23b. Was decedent in the past 12 1 □ Yes 2 0 9 □ Unknown	2 months? □ No	1□L 4□P	ve birth	e of pregna 2  Fetal at time of de	death 3	□Ectopic pregnancy □ Other (specify)				ate of deliv	ery Day Year
res that igned b be deta	y P	Part II. Other signi	ificant condition	ns contributing	to death	but not resu		underlying cause give		23e. Did	tobacco use co	ntribute to t	he cause of death?
w require been sig should b	ed to	CONO	1 ary	My tery	<i>d</i>	Sen.	se, c	tin bet	<sup>2</sup> S	1 🗆	Yes 2√No	3 🗌 Prol	oably 4 Unknown
law re	plet	mel	litu	1+	, 20	er te	nd con	<u></u>		24a. Was		. Were auto	ppsy findings available
The law	E				/ /					perfe	rmed? 2 No	death? 1 ☐ Yes	
ician: Th	Be (	25. Was case reference examiner?	rred to medical					To:		ath (Check only	one)		71
hysic this c	၉	1 ☐ Yes 2 💆	`		Inpat		ER/Outpatio		4 Linuising F	lome 5□Res		ther (Speci	N) (top) ce
Jing F	i o	27. Manner of Dear	5 Pendin	g (	ate of Inj Month, D	ay Year)	28b. Time Injury	Worl	∕at ⟨? Yes 2 □No	28d. Describe	how injury occu	ırrea	
death death ctor: y the	licat	2 Accident 3 Suicide	investiq 6 ☐ Could r	not be	lace of Ir	niury - At ho	ome, farm, s	treet, factory, office	703 2 10	28f. Location	Street and Nun	nber or Run	al Route Number,
efter Dirac d in b	Certification:	4 🗌 Homicide	determ	ined b	uilding, e	etc. (Specif)	1)				wn, State)		
To the Hospital or Attending Physician: within 24 hours eller death.  To the Funeral Director: After this certifice completely filled in by the funeral director.	Medical C	29a. Certifier (Check only one)		Examiner: On t		of examina		ath occurred at the time investigation, in my o					
To th within To th comp	Me	29b. Signature and	d title of certified	ons Pa	lyi	, uns	,	29c. Licenson  () > S  () - S	- HOJ		29d. Date sign	ed (Month,	Day, Year) 26,2006
5		30. Name and add	ress of person	who completed	cause of	death (Item	23a) (Type	Print) St.	Salto.	ms:	2 (30)	×	
Sta	te	31. Date filed (Mar	PRO AYON	2006	Regis	trar's Sign	ure /	astes					
Registra	ar	•	- 0		Contraction		1						

			1 - For State Registrar	State of Marylan		artment of F rtificate of		,	giene 100 0	6	102	63
			Decedent's Name (First, Middle, Last	t)				2. Date of Dea Month		Vasa	3. Time of	f Death
	Physici /Medic		Opal Vernice	Taylor				March 1	Day 8, 2006	Year	6:05	am M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County	of Death		
			11270 Evans Trail	Ct. #104		Beltsvil	le		Prince	e Geo	rge's	
	Funeral		Social Security Number     6. S	**		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	3		lace (State (	or Foreign
	Director		246-50-0922	□M 2ØF 70	Yrs.			May 14,			age,	
	p k		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside C	ity Limits
	sho	ō										2 □ No
	28a-1	ect	Maryland Prince Ge	orge's Belt	sville	10f. Zip Code			10g. Citizen of W	Vhat Coun	trv?	
	death with the Maryland ms 23s or 28s-f show rmust be notified at	Funeral Directo	11270 Evans Trail	C+ #10%								
	ns 23	era	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	20705 Was Decedent of F	lispanic Origin? (S	pecify Yes or No-	United S	STATE - Americ		
	fler c	臣	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		f Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	Blac	k, White,	etc.	
ກິ	urs a	þ	3	If Yes, Give Year or Dates:		1 □ Yes 2 🔯 No	Specify:		Specify	Blac	k	
3-003e	filed within 72 hours after Hygiene. ither than "natural", or its int, the Medical Exercine	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation	deina	16b. Kind of Bu			
V	thin thin	10a. State 10b. County 10c. City, Town or Location  Maryland Prince George's Beltsville  10e. Street and Number 10f. Zip Code  11270 Evans Trail Ct. #104 20705  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1   Yes 2 Mo   If Yes, specify Cuban, Mexican, Puerto   If Yes, Give   Year or Dates: 1   Yes 2 Mo   If Yes, Specify Cuban, Mexican, Puerto   If Yes, Give   If Yes, Give										
7	ed wi	ဦ ပ	10		Super	visor			Hot			
	d oth	a	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Sumam	θ)		
<u>X</u>	Men	2	Willie J.	Alston			Phebia .					
Ma	2 sh and ts m		19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street	and Number or Ru	iral Route Numbe	r, City or Town,	State, Zip	Code)	
e)	and the state of t		Donna Taylor/Daug	hter	11270	Evans T	rail Ct.	#104 Be	1tsville 20c. Location -	Situation To	2070	5
Ö	Se in se		1 X Burial 2 ☐ Cremation 3 X	Removal from State Mt	emetery, crei	natory or other pla A.M.E.Z metery	ion			•		
Baitimore,	rtmer rtant rtant		4 Donation 5 Other (Specific					25,2006	Carth	age,	N.C.	
g	permit. Pages 1 and 2 should be Department of Health and Menia Important: if item 27 is marked any injury or other traumatic wone.		21. Signature of Funeral Service Licer				ss of Facility Lth Funer		37	1 0	2832	27
		_	23a. Part1. Enter the disease, or com-	M00956 Dilications that caused the deat			Street,			h Car	Approxima	te
	Dhusisian		shock, or heart failure. List only Immediate Cause (Final								Interval Bei Onset and	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq								
	Examiner			,								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):							
	ocuted nd transi	Examiner	that initiated events	c. 1								
Š	e exe	EX	resulting in death) Last	Due to (or as a conseq	uence of):							
0/8 8/6	the death certificate be executed y the attending physician and tched for use as the burial-transit	dlcal	•	d								<del> </del>
Ď X	eath certific attending p	Me	IF FEMALE:	000 16								
X P	attenc attenc	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	death 3	Ectopic pregnancy Other (specify)	y		23d. Date Mor	e of delive nth	,	Year
j	by the a	Physician/Me	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at time of d 9☐Unknown	leath 5	Uther (specify) _						
7.		H.	Part II. Other significant conditions of	ontnbuting to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contr	nbute to th	e cause of	death?
g,	w requires that s been signed b should be deta	d by						1 🗆 Y	es 2□No	3 Prob	ably 4 🔣	Unknown
cora	w req beer shou	Completed						24a. Was a	an 24b V	Vere auto	nsv findings	available
ě Y	sician; The taw certificate has t irector, page 2 s	Ĕ						autop. perfor	med? d	death?	npletion of o	cause of
Vital			25. Was case referred to medical				26 Place of Dea	1 ☐ Yes ath (Check only or		Yes	2 No	
5	/sicla s cert direct	To Be	examiner? 1 ☐ Yes 2 ∏ No	Hospital: 1 Inpatient 2 I	ER/Outpatier	nt 3□ DQA Ott	000	lome 5 PResid		er (Specifi	,)	
ō	iding Physician; th. After this certifics funeral director, f		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				ow injury occurr		,	
<u></u>	Attendin death. ctor; Aft y the fun	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		mjury		Yes 2 □No					
DIVISION	of or Attend after death Director; d in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Numbern, State)	er or Rura	l Route Nun	nber,
בֿ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Cer		3, 3.3. (5)333							***	
	Hospi 4 hou Funer ely fill	cal	(Check only 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina	wledge, deat	h occurred at the till vestigation, in my o	me, date and place	e, and due to the our	ause(s) and mai	nner as st	ated. the cause(	s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed			
	D M C O		255. Signature and title of certifier	12/2			_	'	_	_		
	SI		In Jon 9		N 17	2/	2775		3-1	8.6	6	
			30. Name and address of person who Frederick G. Barr,				00 01	- 01	MD 000	1 5		
	Sta	te	31. Date filed (Month, Day, Year)	MD 5454 Wisc 32 Registrar's Signa	TOHSIN	Ave. #13	ou chev	y chase,	MD 208.	1.5		
	Registr		MAR 2 0 2	006	OF AND							

**Physician** /Medical

Examiner

Be Completed by Funeral Director

္ရ

Certification: To Be Completed by Physician/Medical Examiner

Medical

29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TES US H. TAN M. D. 4 Brondway F

6

32. Registrar's Signature

**Physician** /Medical

Examiner

within 24 hours efter death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed

**Funeral** Director

		State	of Maryl		•		Health and I	Mental Hyg	giene	-	10001
					ertifica	ate of	Death	F	Reg No U	6	10264
Decedent's Nam	ne (First, Middle	, Last)						2. Date of Dea Month	ath Day	Year	3. Time of Death
			aymond T	aylor					ch 11, 200		8:30 A.M.
ta. Facility Name (							4b. City, Town, or L	ocation of Death	4c. County	of Death	h
F. Casial Cassults A	-	Egle Nursi	<u> </u>	and the sale to the termination	- If Lind	der 1 Year	Lonaco				legany
5. Social Security N	5602	0. 357 M 2□ F		yrs. last birtho	Month		Hours Min.	8. Date of Birtl (Month, Da) May 24	/, Year)	9. Birti	nplace (State or Foreign untry) Maryland
Usual Residence o 10a. State	10b. County		10c.	City, Town o	r Location					T	10d. Inside City Limits
Maryland	<i>A</i>	Allegany					Lonaconing				1 Yes 2 No
10e. Street and Nu					10f. Z	Zip Code	Lonaconing		10g. Citizen of	What Co	untry?
	57.	ackson Str	eet				21539			US	
1. Marital Status		12. Was D	ecedent Ever i	n U,S.	3. Was Dec	cedent of h	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-	14. Ra		rican Indian,
1 Never Mari 3 ☐ Widowed	ried 2 ☐ Marri 4 ☐ Divorced	ed 1 Ye	Forces? es 2 ☐ No Give er Dates: <b>/ Ç</b> 44		If Yes, sp 1 ☐ Yes	51	Specify:	Rican, etc.)	Bla Specif	ck, <b>W</b> hite y:	white
<b>(0</b> :	15. Decedent	s Education		16a. De	cedent's Us	sual Occup	pation	100	16b. Kind of B	usiness/l	
Elementary/Seco		t grade complete	e (1-4or 5+)	(G lit	ive kind of w e. DO NOT	work done 'use retire	during most of world)	ang			
			0				Painter			Consr	tuction
7. Father's Name							18. Mother's Nam	e (First, Middle,	Maiden Surnar	ne)	
		Edwin Fran	cis Taylor					Sara	ah Fairgrie	eve	
19a. Informant's N Br		ander - Nie	ce	19b. M	ailing Addre		t and Number or Ru. 36, Route 4,				
Oa. Method of Dis	position		20	<ul> <li>Place of Di cemetery,</li> </ul>	sposition (N	Jame of		Date	20c. Location	City or T	Town, State
Burial 2	☐ Cremation 5 ☐ Other (Sp		om State		rel Hill	Cemete	ery	March 14, 2006			ls, Maryland
Donation 21. Signature of Fi	Cremation 5 Other (Sp	ecify) icensed	J. J.	Lau Lau	rel Hill ( 22. Name	Cemeto and Addre	ery  sss of Facility Eich 8 East Main	March 14, 2006 horn-McKe St.,Lonaco	Mosco enzie Fune ning, MD	w Mil ral Ho	ls, Maryland ome P.A.
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29c. License number

FROSTBURY, MD 21532

29d. Date signed (Month, Day, Year)

12006

State Registrar

			For State	State of Ma	arylan				lealth a Death	and Me		iene	006	10265
			1. Decedent's Name (First, Middle, Las	st)			Iniou		500111	1 2	2. Date of Deat	th		3. Time of Death
F	Physicia	an	Ethe1	С.	Va	nderma	rk			1	Month March	Day	2006 Year	6:35 A M
	Medio/ Examin		4a. Facility Name (If not institution, give			muerme	_	, Town, o	r Location o		141011		County of Death	
	CXaiiiiii	lei	Tranquillity of F		owne		Fr	eder	ick				Frederi	ck
F	uneral		5. Social Security Number 6. S	ex 7. Ag		last birthday)	If Unde	r 1 Year Days	If Under	24 Hrs. 8	B. Date of Birth (Month, Day)	Year)	9. Birth	place (State or Foreign
	rector		179-28-8230	□M 2X)F	71	Yrs.	Months	Days	Hours	(VIII.)	vov. 8,	193	34 Penn	sylvania
P			Usual Residence of Decedent		100 Cit	y. Town or Lo								10d. Inside City Limits
arylar	a how	_	10a. State 10b. County PA Luzer	ne	100. 010	Exeter		orou	g h					1 ▼ Yes 2 □ No
e W	8e-f	octo						p Code				On Citi	zen of What Cou	Into/2
with ti	s or 2	듬	10e. Street and Number	4			101. 2	•	643				ted Sta	•
U K I K I S-0000 filed within 72 hours atter death with the Maryland Hyolene.	8 23.	Funeral Director		t. 12. Was Decedent	Ever in U	S 13.1	Was Dec			gin? (Spec	ify Yes or No-		14. Race - Amer	
ter de	Hem Term	nu	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		.5.	If Yes, sp	ecify Cuba	an, Mexican	, Puerto R	ify Yes or No- ican, etc.)		Black, White	
Is at	P. C.	by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 <mark>∏</mark> No	Specify:				Specify: W	hite
5 por 2	etura Galf.		15. Decedent's Ed	lucation		16a. Dece	dent's Us	ual Occup	ation	A of seadon	_	16b. Ki	nd of Business/l	ndustry
2 in 12 in 1	C W	Completed	(Specify only highest gra	College (1-4or	5+)	life.	DO NOT	use retire	during mos d)	t of working	9			
d with	- 3	mo	Clothonary, cosonidary (6 12)	2		Court	Ste	nogr	apher				icial S	ystem
1 0 E	vent.	Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Sumame)	
uld b	tic e	10	Clarence Edga	r Fette	rman				Rho	da	Brig	ght		
sho and t	e me		19a. Informant's Name/Relationship (				•						r Town, State, Z.	
and and	n 27 ser tr		Richard Major / N	lephew	1001 5		_	and the same of th	y Way	100.00	-		aryland	
S - S	important: if item 27 is marked other then "netural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be inclified at once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from State		Place of Dispo cemetery, crea	matory or	ame or other plac		Da			cation - City or I	
mit. Pages	ant:		4 ☐ Donation 5 ☐ Other (Specific	y)		edericl				3/21/2			lerick,M	
ermit epart	any in		21. Signatore of Funeral Service Licer	isee										es, P.A.
م م	- a a	N A	Raymonate	corpor)									ick, MD	21702 Approximate
			23a. Part : Enter the disease, or com shock, or heart failure. List only	one cause on each i	ine.					cardiac or	respiratory arr	est,		Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition	_ Cerebr	al Va	scular	Acc	iden	t					
	edical miner		resulting in death)	Due to (or as Left H				Doby	droti	on				Mos
		<u>_</u>	Sequentially list conditions,	b. Due to for as			VILL	Delly	uracı	OII				1100
pe	ısıt	들	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Failur			2							Mos
хөсп	and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseq	juence of):							-	
ortiticate be executed	physicien and the burial-transit	dical E		Hypert	ensid	n								Mos
DO /	phy:			_ u.										
DX D	been signed by the ettending p should be deteched for use as i	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			75						23d. Date of deli	very
death	d tor	Cia	in the past 12 months? 1 □ Yes 2 ☑ No	1☐Live birth 4☐Pregnant a			⊒Ectopic ☐ Other (	pregnanc specify) _	y 				Month	Day Year
) å	by the	Physi	9 Unknown	9□ Unknown							-	1		
ords, P.O	ne del	by P	Part II. Other significant conditions of	contributing to death I	but not res	sulting in the u	underlying	cause gr	ven in Part I	l.	1			the cause of death?
COLO:	en sig		Depression								1 🗆 Y	es 2 <sup>N</sup>	ŽNo 3 ☐ Pro	obably 4 Unknown
aw E	2 sho	Completed									24a. Was autop	SV	24b. Were au	topsy findings available completion of cause of
E e	ate has	E									perfor	rmed?	death?	2 No
VITAL M	iis certificate has l director, page 2 s	Be C	25. Was case referred to medical examiner?							e of Death	(Check only o	ne)	- 1	ssisted
OT V	<u>∞</u> 0	2	1 ☐ Yes 2 ₹ No			ER/Outpatie		NON					6 ⊠Other (Spec	Living
	Je Je		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time o Injury		28c. Inju Wo			8d. Describe h	low inju	ry occurred	
VISION OF VITA Attending Physician:	tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be			1	М		]Yes 2 □		Of Legation (C	etra at an	d Number of P	ıral Route Number,
DIVISION i or Attending	2 2	Certification:	4 Homicide determined		itc. (Speci	iome, tarm, st fy)	reet, tact	ory, office		-	City or Ton			rai Aoule Number,
Hospital	tilled in		The Court of the Countries III	nyeician: To the bee	e of market	midadas dan	th san as	et and there is	mis afatic as	otelana a	nd days to the c	marie Wel	Landmann Fas	etato/
Hos	F F	edical	(Check only one)	miner: On the basis and manner s	of examina	ation and/or in	rvestigati	on, in my	opinion, dea	ath occurre	d at the time,	date and	d place, and due	to the cause(s)
To the	To the Fun	Me	29b. Signature and title of certifier		01		. 2	9c. Licen:	se number			29d. Da	te signed (Monti	h, Day, Year)
F 3	F - 0		1/1/00m	Koil	le	MU	7	D54	749			Mar	ch 20,	2006
CX			30. Name and address of person who	completed cause of	de un tei	m 23a) (Type	, Print)							
8			Dr. Allen Reilly		11			l, Fr	ederi	ck, M	m 2170	1		
	St	ate	31. Date filed (Month, Day, Year)	32. P	trar's Sign	ature								
,	Regist		MAR 21	ZUUb A	eve-	K A	Low	1						

			1 - For Registrar	State of Maryla		artmen <i>rtificat</i>					ene 3000	5	10266
. Ares	Physici /Medic		1. Decedent's Name (First, Middle, Last, Salvatore Charles							Date of Death	8, Day 2006	Year )	3. Time of Death 10:05P .M
	Examir		4a. Facility Name (If not institution, give Laurel Regional F	Mospital		Ĺ	aure.						e George's
	Funeral Director		5. Social Security Number 577-28-5093 6. Security Number 10 10 10 10 10 10 10 10 10 10 10 10 10	7. Age (In y	32 Yrs.	If Under Months	1 Year Days	If Under Hours	Min. J	Date of Birth (Month, Oay 1ne30,1	923	Cou	place (State or Foreign ntry) nington, D.C.
	Maryland a-f ehow	ctor	10a. State  10b. County  Maryland Prince Ge	_	City, Town or L								10d. Inside City Limits 1 ☐ Yes 2 XNo
	th with the 23e or 28	ai Director	10e. Street and Number 11419 Allview Driv	7e		10f. Zip	Code 2070	)5			g. Citizen of W United		
9036	be filed within 72 hours after death with the Maryland tal Hyglene. Id other then "naturel", or Iteme 23e or 28e-f show event, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW		Was Deced If Yes, spe- 1  Yes	спу Сива	spanic Ori n, Mexican Specify:	п, Риело на	y Yes or No- an, etc.)		k, White	ican Indian, , etc. White
Baltimore, Maryland 21215-0036	e filed within 72 h il Hygiene. other then "netu vent, Ine Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)			dent's Usua kind of wo DO NOT u			t of working	1	C.I.A		ndustry
/land	2 should be filed and Mental Hygie is marked other eumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Anthony Valenti							First, Middle, M e Carus	aiden Sumame O	9)	
, Mary	es 1 and 2 should b of Health and Ment of Item 27 is marked ir other treumatice	1	19a. Informant's Name/Relationship <i>(Ty</i> Nida L. Valenti -wi	рө, Print) .fe	19b. Maili 11419	ng Address All	(Street a	Driv	er or Rural F e Belt	Route Number, CSV <b>i</b> lle	City or Town, S , Mary 1	State, Zi Land	20705
timore	permit. Pages 1 & Department of He Importent: If Item any injury or oth		20a. Method of Disposition  143 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)	emoval from State Ga		matory or d Heaver	n Cer			3/200€		Spr	own, State ing, Marylan
Bal	Departimon Importany in		21. Signature of Funeral Service Licens  Denulal USS	rewards	44	400 Pc	owder	Mil	1 Road	l Belts		PA Mar	yland20 <b>7</b> 05
8760,	Physician / Medical Examiner supply sician and physician and supply sician and supply	dical Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	L Thrombequence of): Heart equence of):	oosis		9, 300, 40					Approximate Interval Between Onset and Death minutes hours
O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ Fi 4 □ Pregnant at time o 9 □ Unknown	etal death 3[	⊒Ectopic pi ⊒ Other (sp	regnancy pecify)		• • • • • • • • • • • • • • • • • • • •		23d. Date Mon		very Day Year
Δ.	Se Co	P	Part II. Other significant conditions con Hairy Cell Leuken						•			ibute to	the cause of death? bably 4 X Unknown
Il Recoi	The law ate has t page 2 s	Completed	Septicemia; Pneum	nonia						24a. Was an autopsy perform	, p	rior to co	opsy findings available ompletion of cause of
Division of Vital Records,	el or Attending Physicien: Th s after death. sl Director: After this certificate ed in by the funeral director, pag	Certification: To Be	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year,	ER/Outpatie		28c. Injury Work	er: 4 □ Nu	ursing Home		nce 6 ⊡Othe		fy)
Divis	tel or Att rs after de el Direct ed in by t		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, st poify)	reet, factor	y, office		281	Location (Str City or Town,		er or Rui	al Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	ledical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the best of my laner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred ivestigation	at the tim , in my op	ie, date an pinion, dea	nd place, and th occurred	at the time, da	te and place, a	ind due	to the cause(s)
) ,	o with a	×	29b. Signature and title of certifier Wullam	-1000	aven	14)	c. License	(V)	39	16 M	d. Date signed arch 19	, 20	
(	V. '		30. Name and address of person who co William A. Warren			Print) Porge	Stre	eet L	aurel,	Maryl	and 207	07	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 0 26	32 Aegistrar's Sig	gnature	ede	,						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** KATHRYN MALET VERNON /Medical 4c. County of Death 4h City Town or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 0 VIEMOVIC If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 F Yrs. 79 079-20-7747 MARCH 1. 1927 **NEW YORK** Director Usual Residence of Decedent death with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1 XYes 2 No EASTON Director MD. TALBOT 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 21601 207 IDLEWILD AVE. U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race · American Indian, or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: WHITE 3 Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4or 5+) **EDUCATION** SECRETARY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fil timent of Health and Mental H tant: If Itam 27 Is marked oth jury or other traumatic avan Be PETER MALET MARY Α. CONLON 2 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 207 IDLEWILD AVE. EASTON, MD. 21601 ERNEST C. VERNON / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page
Department of
Important: If
sny injury or CHES. CREM. CTR. 3-19-06 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alheroscleashie Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner to the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 DUnknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2, No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ို After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Naturaf 5 Pending investigation To the needs after death.

You the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To Contifying Physicians To the best of my knowledge, death occurred at the time, date and place, and direct the natiosals) and meanur as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 607 Dukhman LANE EASTON 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 2 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** P M ELLEN JEMMIA WILES MARCH 17 2006 5:45 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🗶 F 220-16-1215 1922 83 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itsms 23a or 28a-f show the Madical Exempler: ust be notified at 1√ Yes 2 No MD Frederick Director Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 S. Church St. 21769 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "ns sny injury or other traumatic avent, Ite Maule 2006. (Give kind of work done during most of working life. DO NOT use retired) federal College (1-4or 5+) Elementary/Secondary (0-12) government <u>lab technician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George E. Wiles Ruth Eleanor Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myrie Taylor (Sister) 4199 Palimino Ln., Middletown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 2 Cremation 3 Removal from State N XBpria Lutheran Cemetery 3/21/06 4 □ Donation 5 □ Other (Sepcity) Middletown, MD Sign, ture Fum ral Service Lc nsee Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line: Approximate Interval Between Onset and Death Immediate Cause (Final 5 Day **Physician** disease or condition resulting in death) 46017 ang estive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Disease 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 2, No 1 Yes 2 No Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 Tyes 2 No 24 hours after death. 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2/ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shah Heren, ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick homas co [honson 31. Date filed (Month, Day, Year) 1 2005 32. Re State Registrar

	7		1 - For State Registra MEND#35per		Marylan PS,McCo		artmen rtificat			ınd Me		giene Reg. No.	306		269
	Physici /Medic		Decedent's Name (First, Middle     Allen Warshaw		·						2. Date of Dea Month March	Day	Ye	ar	ne of Death
	Examin		4a. Facility Name (If not institution 15416 Indiano		ber)		4b. City,	Town, or Derw	Location of	f Death			ounty of County of Co		
	Funeral Director		5. Social Security Number 579-54-4775 Unknown	6. Sex 13∑ M 2 ☐ F	7. Age (In yrs. 64	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da JAN • 1	h Y Year) 7, 19	9. 142 V	Birthplace (S Country) Vashing	gton, DC
	Maryland f show	ior	Usual Residence of Decedent  10a. State 10b. County  Maryland Mont	gomery	10c. Cit	y, Town or Lo Derwo									de City Limits ¥Yes 2 ☐ No
	with the ? 3a or 28a- It be notifi	Direct	10e. Street and Number 15416 Indiano	la Drive			10f. Zip	Code 208	55		1	•	en of Wha	•	America
036	be filed within 72 hours after death with the Maryland itel Hygiene id other then "naturel", or Items 23a or 28a-f show event, I'ne Medical Examiner must be notified at	by Funeral Director	11. Marital Slatus  1) Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	ces? 2 <b>XX</b> No e		Was Decedif Yes, spe		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)			American India White, etc. White	an,
21215-0036	d within 72 ho giene. ir then "natur the Medical.	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-	4or 5+)		dent's Usu kind of wo DO NOT u	rk doné d se retired,	ition uring most	of workin	g			ess/Industry Governr	ment
Q	_ 0 9	0	17. Falher's Name (First, Middle, Louis Warsh								(First, Middle, Green				
, Mar	permit. Pages 1 and 2 should be Department of Health and Mente Important: if Item 27 is marked any njury, or other treumatic ev ance		19a. Informant's Name/Relations Howard Warshaw			670	Ameri	cana	Driv	7e, #	Route Number	apo1i	is, M	D 21403	
Baltimore,	Pages 1 ment of He ant: If Iter ury or oth		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S				Memo	rial	Gard	1. 03	/19/06	Fa]	lls Cl		VA
Balt	pemit. Depen Impert		21. Signature of Funeral Service	hac		1	1800	New	Hamps	shire	Ave.	Silve		ring, l	e, Inc. MD 20904
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a	used the deat ach line. DCardia or as a conseq	1 Infa			g, such as	cardiac or	r respiratory a	rest,		Interva	ximate al Between and Death 1e
,092	rate be executed shysicien and the burial-transit	Ical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	C	or as a conseq										
.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta ant at time of d	I death 3	∃Ectopic p ∃ Other (s <sub>i</sub>					2	3d. Date of Month	f delivery Day	Year
Δ.	quires that n signed by uld be deta	ρ	Part II. Other significant conditi	ons contributing to de	ath but not res	ulting in The u	inderlying (	ause give	en in Part I.		1	_	_	te to the caus	e of death?
Il Records,	: The law require cete hes been si, page 2 should b	Completed			· · · · · · · · · · · · · · · · · · ·			·			24a. Was autor perfo 1 Yes	rmed?	prior deat	to completion	
Division of Vital	ing Physicien: 1 i. After this certificet uneral director, p.	ion: To Be	25. Was case referred to medical examiner?  1½ Yes 2 □ No  27. Manner of Death  1 □ Natural 5 □ Pendir	Hospital: 1 ☐ In	npatient 2  of Injury h, Day Year)	ER/Outpaties 28b. Time of Injury		28c. Injun Worl	9r: 4 □ Nu	rsing Hon	(Check only only one 5 XResides 1884. Describe 1	dence 6		Specify)	
Division	f or Attending after death. Director: After d in by the fune	Certification:	2 Âccident invest 3 Suicide 6 Could 4 Homicide determ	not be 28e, Place	of Injury - At h	ome, farm, st			.63 2		28f. Location (: City or To			or Rural Route	a Number,
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: Atter completely filled in by the funer	Medical C	29a. Certifier 1 XCertifyi: (Check only 2 Medical one)	ng Physician: To the Examiner: On the ba and mann	isis of examina	owledge, deat ation and/or in	th occurred vestigation	al lhe tim	ie, date an pinion, dea	d place, a	and due to the	cause(s) date and	and manne place, and	er as stated. due to the ca	use(s)
	To the To the comp	Me	29b. Signature and tilte of certifie	73 Silve	'emer	m		c. License	27985				_	Month, Day, Ye	_
			30. Name and address of person William H. Si	lverman, M	D 12	01 Sex	zen L	ocks	Road	, Sui	te 111	, Roo	ckvil	le, MD	20854
· No.	Sta Regist	ate rar	31. Date filed (Month, Day, Year, MAR 2	0 2006	gistrar's Signa	J. A	goesti.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Qay Year **Physician** MARCH 2006 10:35AM FRANCES CHURCHILL WIERUM 14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TALBOT 4442 BAILDON ROAD TRAPPE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Min. Months Hours  $\mathbf{P}_{\mathbf{A}}^{(y)}$ 1 □ M 2 X F 103 Yrs. 055-38-7817 Director Usuel Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show Its: Medical Examiner must be nothing at 1 Yes 2 No Director TALBOT TRAPPE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4442 BAILDON ROAD 21673 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, a filed within 72 hours after de al Hygiene. other than "natural", or Items Black, White, etc. 1 Never Married X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 27 Is markad othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should ba fill of Haalth and Mental H fitem 27 Is markad oth Be FRANK FRANCIS WOODS VIRGINIA LEE HALL ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 48 FOREST ROAD, DEMAREST, NJ 07627 CARL WIEROM/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition parmit. Pages 1 Department of H Important: If ite any injury or ot ang injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 3/16/2006 STEVENSVILLE, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): ne the attending physician and hed for use as the burial-transit that the death certificate be axecuted Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 1 Yes 2 No detached 9 Unknown sate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Cerebouras una disease 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes Hospitel or Attending Physicien: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Cther: 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) ဂ္ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funeral C 1 No Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 atthe DSZZSI

State

31. Date filed (Month, Day, Year) 6 200

MATTHEW FISCHER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Registrar

Easter Montand 2160

			1 _ State	State of Marylan	•	artment of H				
			Registrar  1. Decedent's Name (First, Middle, Last)			incate of L		2. Date of Dea	eg. No.	3. Time of Death
	Physici	an						Month	Day Yea	1 0 6 1
	/Media		Daisey Rosett		ngfield			March	15 2006	9:10 P <sup>M</sup>
2	Examir	ner	4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Deati	1	4c. County of De	
			Ruxton Health Car		land birth days	Denton If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Caroline	
	Funeral		5. Social Security Number 6. Sex	M 2 F 7. Age (In yrs.	Yrs.	Months Days	Hours Min.	(Month, Day	Year)	irthplace (State or Foreign Country) CVland
	Director		222-10-6137 Usual Residence of Decedent	89				Oct.1,	1910 Mai	ryrand
	land bw		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Many	to	Manual and Damahaata		Rhodes	dala				1 ☐ Yes 2 🗗 No
	28e	rec	Maryland Dorcheste 10e. Street and Number	<u>r</u>	Milodes	10f. Zip Code		1	0g. Citizen of What	Country?
	3e or	ī	5723 Finchville	Reliance Roa	ad	21659			USA	
	Jeath Jeath	Funeral Director		2. Was Decedent Ever in U.		Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (S	pecify Yes or No-	14. Race - Ar	nerican Indian,
(0	r Ite	Fur	1 Never Married 2 Married	Ammred Forces? 1 X Yes 2 ☐ No	1			o Rican, etc.)	Black, W	nite, etc.
03	el', o	b	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I□Yes 2⊠No	Specify:		Specify:	Black
21215-0036	within 72 hours after death with the Maryland ene. then *neturel', or flems 23e or 28e-f show fre Medical Exertiret reast be notified at	ted	15. Decedent's Educ (Specify only highest grade		16a. Deced	lent's Usual Occupa	ition	rkina	16b. Kind of Busines	ss/Industry
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	filed within Hygiene. other than ent, II e M	Completed		4	Nurse	<u> </u>			Educat:	Lon
Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, i		
<u>yla</u>	Meni Meni arke	2	Rufus F. Evans					F. Nicho		
a	2 sho and Is m		19a. Informant's Name/Relationship (Typ	•	1				, City or Town, State	
	and ealth m 27		Berneda Crockett /		The state of the s		le Relia			Le,Md.21659
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or items 23e or 28e-f show any injury or other treumatic event, the Medical Exacting the notified at once.		20a. Method of Disposition  1    Burial 2 □ Cremation 3 □ Re		riace of Dispo cemetery, crer	sition (Name of natory or other place	g)	Date	20c. Location - City	or Town, State
Ë	Pag ment ent:		'4 □Donation 5 □ Other (Specify)		and the second second	ans Cem.		0-2006	Hurlock,	Maryland
att	Depart Import any inj		21. Signature of Funeral Service License	•)	22	Name and Addres	s of Facility Lth Fune	ral Home		
Ш_	20 E # 9		Mrscella 1	ands	Ē	16 S. ma:	in Stree	t, Hurlo	ck,Marylaı	nd 21643
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	e cause on each line.				or respiratory arr	est,	Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					
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8760,	ate b	dlcal	d							
9	leath certific attending p	a a	IF FEMALE:	to If was outcome of progre	2001					
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	Ic. If yes, outcome of pregna 1 Live birth 2 Feta	ıl death 3 [	Ectopic pregnancy			23d. Date of o	lelivery Day Year
0	the a	slc	1 ☐ Yes 2 No 9 ☐ Unknown	4☐ Pregnant at time of d 9☐ Unknown	leath 5∟	Other (specify)				
Ρ.	es that the death igned by the atte be detached for	by Physician/M	Part II. Other significant conditions con-	cributing to death but not res	ulting in the u	nderlying cause give	on in Part I	23e. Did to	bacco use contribute	to the cause of death?
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Vital	Physicien: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	nanital:		Otho		ath (Check only on		William DV = 1
of		2	1 162 5 140		ER/Outpatier		4 Nursing F		ence 6 Other (S)	pecify)
n	ding Phy h. After thi funeral c	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		280. Describe no	ow injury occurred	
Division	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	On Diversification Alb	(		res 2 □ No	29f Location /C	troot and Mumber or	Rural Route Number,
Σ	or Ai	rtif	4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	fy)	еет, тастогу, опісе		City or Town		nulai noute Nulliber,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier 1 Certifying Phys	ician: To the best of my kno	awladas dast	accurred at the time	a data and place	and due to the a	aueale) and manas	as stated
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	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License	number	2	9d. Date signed (Mo	nth, Day, Year)
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Beatrice K. Adams 2:00 AM 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner montgomery Holy Cross

5. Social Security Number Hospital 6. Sex Silver Spring If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months Min. 1 □ M 2 F 095-22-6169 71 Yrs Director New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow A Health and Mental Hygiene. Item 27 ie marked other then "naturel", or iteme 23s or 28s-1 ehov other traumatic event, the Modical Examinar must be notified at 1 No 2 No MD Silver Completed by Funeral Director Montgomeru 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? Woonsockett Lane 309 20905 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Governmen 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental Heart: if Item 27 is marked off Jury or other traumatic even Be nearge Anna Laura Dawis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Woonsockett Ln. Silver Spring MD 20905

20c. Location - City or Town, State Colleen Jackson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State permit, Page Department of Importent: if any injury or ance. Chesapeake Crematon 3-31-06 Belts VIlle, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fallity Rapp Funeral + Cremation 21. Signature of Funeral Service Licensee services mo1358 933 Gist Ave. Silver Spring, MO 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sepsis weeks /Medical Due to (or as a consequence of): Examiner Catheter Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last weeks Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burlal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: . If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be Chronic Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Hypertension has 2 No 1 Yes ours after death. Ieral Director; After this certifice filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 3-30-06 109 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suresh Ki Grupta 9801 Greangla AVE #220

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 4 200

32. Registrar's Signature

Silver Spring, MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day March 31, 2006 Year 1:20 AM M **Physician** Ruth Adamson /Medical 4a. Facility Name (If not institution, give street and number)
Gilchrist Center for Hospice Care 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Date of Birth (Manth Day Year) 07/21/1925 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1□M 2KF MD 212-20-6788 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County worle rthan "netural", or items 23a or 28a-f ehor the Miccigal Examinar must be nutified at 1 Yes 2 No Baltimore MD Baltimore City Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 United States 5620 Laurelton Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Heelih and Mental Hygiene. Important: If tem 27 is marked other them. In the many of the permitted of the many of the permitted of the many of 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education Stationary (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Payroll Master 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Geneva Dorman James Adamson 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5620 Laurelton Avenue Baltimore, MD 21214 Miss Ruth Adamson/Self 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Apr 1 20a. Method of Disposition 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee <sup>22</sup>Cremation and Funeral Alternatives 48800M 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vecto-Sigmoid ear colon concer **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit The faw requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 2 No 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 to ther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this 28d. Describe how injury occurred ierel Director: After th 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medicai Certification; 27. Manner of Death 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours efter To the Funerel Dire the Hospital 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely i (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 025205 March 31, 2006 , und 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Binc N. Charles St. Balts. Md 2120/ 6781

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 4 2006

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Haamson,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 1702 pm 2006 ipr. /Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE let/gzot/ 1/14 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or other treumatic event. The Medical Examiner must be notified at 1₹Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 or items 23a Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Affiled Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates: | 944-46 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify Specify: Black 3 ₩ Widowed 4 Divorced 'naturel', 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) le marked other than Elementary/Secondary (0-12) College (1-4or 5+) ould be filed within Mental Hygiene. TEELWOIKER NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 19a\_Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If Item 27 le m any njury or other treum doublike 20b. Place of Disposition 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemo Rehase day /Medical Due to (or as a consequence of) Examiner YPER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque) burial-transit Due to (or as a consequence of): 68760the attending physicien Physician/Medical for use as the IF FEMALE: Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 🔀 No 3 Probably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▶ No 24a. Was an certificate has autopsy 2 No 1 Tyes Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatrent 2 ER/Outpatient 3 DOA Division of After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funerel Direct completely filled in by determined 9 Certifying Physician: To the bast of my knowledge death occurred at the time, date and place, and due to the cauco(e) and manner ac etated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D321 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Registrar

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31. Date filed (Month, Day, Year)

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22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last 2 Date of Death **Physician** Month CH Day خالات 2886 9:20 FM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Center Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 2/2-30-88 78 1 M 200/F Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 77 is marked other then "naturel", or items 23s or 28s-f ebov traumatic event, the Madical Examinar must be notified at MIJ 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubar, Mexican, Puerto Rican, etc.) 11. Marital Status in U.S 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 □ No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 4or 5+) allston WISOr 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental nformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) 2,084 Department of Heelth a importent: if item 27 is eny injury or other traignes. edSau JarkHsville 9 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Forest Hill MD Vans Funeral Chape 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service Licensee 22. Name and Add ss of Facility -orest 21050 arrigid 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HOURS Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner COAGULOPATHY 6 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit RENAL FAILURE HUUKS Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physicien by Physician/Medical use as the attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No been si 3 Probably 4 Unknown 1 Tes Completed s certificete has b lirector, page 2 st 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this After thi 27. Manner of Death
1 Natural
2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funerel Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my principle. 29a. Certifier Medical Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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SELL. JEFFREY 31. Date filed (Month, Day, Year) APR 0 State Registrar

29b. Signature and title of certifie

OSLER DRIVE TOWSON, MARYLAND 21204 7601 32. Registrar's Signature 4 2006

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

29c. License number

D 38570

29d. Date signed (Month, Day, Year)

31/06

			101	artment of Health and Mer rtificate of Death	ntal Hygier	71116 111276
	Physic /Medi		Decedent's Name (First, Middle, Last) Teresa Marlena Al-Zyoud	2.	Date of Death Month	Day Year 3. Time of Death 2006 2006 12:45 PM
)	Exami		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death
	Funeral Director		5. Social Security Number 217–98–8626 6. Sex 1 M 2 X F 25 Yrs.	If Under 1 Year	Date of Birth (Month, Day, Yes Oril 12, 1	9. Birthplace (State or Foreign Country) Maryland
	Maryland a-f show	ctor	10a. State 10b. County 10c. City, Town or L Maryland N/A Baltimore	ocatio <i>n</i>		10d. Inside City Limits 1 M Yes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 853 East 30th Street	10f. Zip Code 21218		Citizen of What Country?
9036	172 hours after deeth with the Maryland "natural", or items 23a or 28a-1 show pdigal Examiner must be coulded at		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rici 1 ☐ Yes 2 🗓 No Specify:	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	within ene. than "	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) Buse	dent's Usual Occupation kind of work done during most of working DO NOT use retired)		. Kind of Business/Industry od Service Industry
yland		To Be	Joseph Robert Poliszczuk	18. Mother's Name (Fi Linda L. Mac		(en Sumame)
e, Mar	s 1 and 2 should f Heelth and Mer Item 27 is marke other traumatic		Linda L. MacCord/Mother 853	ng Address (Street and Number or Rural Re East 30th Street Baltim	nore Maryl	and 21218
timor	Page nent o ant: If i		4 Donation 5 Other (Specify)	11ey Mem. Gardens 4/5/06	5 Tim	Location - City or Town, State Onium Maryland
Bal	permit. Depertr Imports any inju			2. Name and Address of Facility 5305 Harford Road Baltin		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	IN Jung	spiratory arrest,	Approximate Interval Between Onset and Death
8760, ~	cate be executed physicien and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  Due to (or as a consequence of):	acertation		5 days
P.O. Box 6	the death certifi y the ettending iched for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
rds, P	sign sign d be	ρ	Part II. Other significant conditions contributing to death but not resulting in the t	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 No 3 Probably 4 Wunknown
Division of Vital Records,		Completed			24a. Was an autopsy performed:	
f Vit	Physiclen: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes № No Hospital: 1 ▼Inpatient 2 ☐ ER/Outpatie	26. Place of Death   Cant   3   DOA   Cther: 4   Nursing Home		6 ☐Other (Specify)
sion o	To the Hospital or Attending Physicien: within 24 hours effer deeth. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	f 28c. Injury at Work? M 1 Yes 2 No	. Describe how in	jury occurred
Divi	oltal or At urs efter d rat Direct lled in by		4 Homicide determined building, etc. (Specify)		City or Town, Sta	
	To the Hospital or within 24 hours ette To the Funeral Directional Completely filled in the Comp	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signal for and title of certifier	h occurred at the time, date and place, and vestigation, in my opinion, death occurred a 29c. License number	at the time, date a	and place, and due to the cause(s)
	F ¥ F 8				230.1	Date signed (Month, Day, Year) March 30, 200 6 y Pkwy Ba Himore MD
	511		30. Nards and address of person who completed cause of death (Item 23a) (Type, FLORELLO SVEN ERIK QUIANZUN UNION	Memoria (Hospita) 2018	University	y Pkny Baltimore MD
	Sta Registr		31. Date filed (Month, Day, Year) a2. Registrar's Signature APR 0 4 2006	E)	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 24a Maryland / Separtment of Health and Mental Hygiene Certificate of Death Reg. No. UUO 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year On 10:20PM Mer 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Baltimore Maryland Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year June 28, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1□M 2€F Country) 214-66-6127 50 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Carroll 1 ☐ Yes 2 🏋 No Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1004 Merridale Blvd. 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes YNO
If Yes, Give
Year or Dates: 1 ☐ Yes 21 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Artist Modeling/Wallpaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donald Kirby Janet Tracy 19a. Informant's Name/Relationship (Type, Print) (Spouse) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1004 Merridale Blvd. Mt. Airy, MD 21771 Mr. R. Gilbert Buckman, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prospect Cemtery 4/5/06 Mt. Airy, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myelogenous Acute 1 months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year 4☐ Pregnant at time of death 9 Unknown 9 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probebly 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P19694

preene St. Baltimore

29d. Date signed (Month, Day, Year)

signed by the attending physicien and debetached for use as the burial-transit Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: Director: After the in by the funeral deeth. within 24 hours after To the Funeral Dire

certificate

this

**Physician** 

/Medical

**Examiner** 

Funeral Director

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10a State

MD

**Funeral** 

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show eny injury or other traumatic event, the Medical Evantinal must be notified at once.

**Physician** 

/Medical

Examine

Physician/Medical

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Completed

2

Certification:

29b. Signature and the of penitier.

31. Date filed (Month, Day, Year)

C.

Philip

MD 30. Name and agrees of person who completed cause of death (Item 23a) (Type, Print)

2008

M.S

32. Registrar's Signature

22 South

ORIGINAL

Examiner

Baltimore, Maryland 21215-0036

State Registrar

			1 - For State Registrar	State of Marylar	nd / Depar			lental Hygie	ene n	06	10070
			Registrar  1. Decedent's Name (First, Middle, La	ns()	Ceru	iicale oi	Dealii	2. Date of Death	No	UU	102/0
	Physic			BARRY				APRIL	Bay	2006	3. Time of Death 9:25 A M
	/Medi Examir		4a. Facility Name (If not institution, gir		4	b. City, Town, o	or Location of Death			y of Death	, , , , , , , , , , , , , , , , , , ,
			GILCHRIST HOSP	ICE		TOWSO	ON		BAI	TINOR	E
	Funeral			Sex 7. Age (In yrs.	, A	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y			ace (State or Foreign LAND
	Director		578-44-0276 Usual Residence of Decedent	1□ M 2□X 77	Yrs.			09/20/	1928	MARY	L'AND
	land bw		10a. State 10b. County	10c. Ci	ity, Town or Loca	tion				10	d. Inside City Limits
	the Marylar 286-f ehow notified at	ctor	MD MONTGOM	ERY	SILVER S	PRING					1 ☐ Yes 2 No
5	ath with th 23a or 20 UNI De DO	D In	10e. Street and Number 3362 CHISWICK C	OURT		10f. Zip Code 20906-	-1633	10g		What Count	ry?
F	death ms 2	Jera	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. Wa		Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-		ce - America	n fndian.
925Am	s 1 end 2 should be filed within 72 hours after death with the Maryland filed and Mental Hygiene. If health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28e-f ehow other traumatic event, the Mudical Exprense must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Married 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		es, specify Cubi ]Yes 2.∏XNo		Rican, etc.)		ick, White, e	
2-0	72 hours "netural",	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deceden	it's Usual Occup	pation during most of working	16	b. Kind of E	Business/Indi	ustry
at 92 21215-0036	i within iene. rthen	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	ATTORN		during most of workind)		LAW		
7	e fileo of the vent,	BeC	17. Father's Name (First, Middle, Las	)			18. Mother's Name	(First, Middle, Ma		ne)	
Var	2 should be filed within and Mental Hygiene. ie marked other then aumatic event, the M	10		RRISON			MARY		ESLIN		
2006 Maryland	d2sh thand t7iem traum		19a. Informant's Name/Relationship (PATRICIA M. SADO)				and Number or Rura BLVD.; AP				
, 0 .	s 1 end 27 Health Item 27 other tr		20a. Method of Disposition	20b. F	Place of Dispositi	on (Name of	0			- City or Tov	
3	Page ient o nt: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	JHemovar from State	cemetery, cremat		INC. 04/0	4/2006	latons	sville	MD
Pril 3,	permit. Pages. Department of P important: if Ite any injury or of		21. Signature of Funeral Service Lice				ess of Facility THE				
April Balt	89 6 8 8						CH RAVEN				
•	Physician /Medical	0,	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	prications that caused the deal one cause on each line.  a	74 (0			r respiratory arrest			Approximate interval Between Onset and Death
	Examiner	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq							
_	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events	c							
Oly 760.	te be execu ysicien and e burial-tra		resulting in death) Last	Due to (or as a conseq	quence of);						
		dical		d							
7 %	eath certifica attending ph for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancv						
- O	death e atte	by Physician/Med	23b. Was decedent pregnant in the past (2 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	aldeath 3⊟Ec	topic pregnancy ther (specify)	<u>′</u>			te of deliver onth E	Y Day Year
2	uires that the signed by die detac	y Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the unde	rlying cause giv	en in Part I.	23e. Did tobac	co use con	tribute to the	cause of death?
ords	Attending Physician: The law requires that the rodenth. octor: After this certificete has been signed by the the funeral director, page 2 should be detache							1 ☐ Yes	2 🗆 No	3 Proba	bly 4 Unknown
ecc	e law r has be je 2 shi	Completed						24a. Was an autopsy	24b.	Were autops	sy findings available pletion of cause of
<u> </u>	: The	Con						performed	7	death?	
Vita	ysician: The lis certificete ha	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death	(Check only one)			
ţ.	Phys r this ral dii	<u>د</u>	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatient 2 2	ER/Outpatient 28b. Time of	3□ DOA Oth	4 🗀 Nursing Hon	ne 5 Residence		ner (Specify)	nospi4
io	nding ath. r: After e funer	atlor	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Worl	k?" Yes 2 □ No	od. Describe now i	njury occur	160	
Division of Vital Record	- 9	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fy)	factory, office	2	8f. Location (Stree City or Town, S	t and Numb tate)	er or Rural	Route Number,
J	To the Hospital or within 24 hours at To the Funeral D completely filled in	Medical Ce	29a. Certifier Check only one) Check only	ysician: To the best of my kno niner: On the basis of examina	owledge, death oc ation and/or invest	curred at the tin	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	e(s) and ma	anner as stal	led. he cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. License				d (Month, Da	
	- S - O		Melan	lins		D5	8303	A	21.	7 70	2020
_	N and		30. Name and address of person who	1	n 23a) (Type, Prir	nt)	U JA KA	7 10:	/. ^	2/204	
Ì	UI		WHON Ch	reks up 66	-1 / -	charle	2 7/ 1/2)	linos	W	4204	1
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	de					

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - State Registrar	State of Maryland /	Certificate of Dea	4h	leg. No. 006 10279						
Physici /Medic	al	1. Decedent's Name (First, Middle, La  ROSE LEE BUSSEY		4.00 7	2. Date of Dea Month	3i 2006 1:15 P.						
Examin	er		GTON MEDICAL CENT		E	4c. County of Death  ANNE ARUNDEL						
Funeral Director			Sex 7. Age (In yrs. last b	rithday) If Under 1 Year If Un Yrs. Months Days Hou	der 24 Hrs. 8. Date of Birth (Month, Day) JULY 8,	year) 9. Birthplace (State or Fore Country) VA						
ms 23a or 28a-f ehow crust be notified at	tor	10a. State 10b. County  MD ANNE AR		vn or Location SEVERN		10d. Inside City Lim 1 ☐ Yes 2 ☐						
23e or 28e ust be not	il Director	10e. Street and Number 625 DONALDSON AV		10f. Zip Code 21144	1	log. Citizen of What Country?						
	/ Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2  No If Yes, Give	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	ican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify:						
"naturel", or ite igologi Examine	Completed by	3	Year or Dates:  Education rade completed)	XX  a. Decedent's Usual Occupation (Give kind of work done during r life, DO NOT use retired)		WHITE  16b. Kind of Business/Industry						
f Heelth and Mental Hygiene. Item 27 is marked other then " other treumatic event, Itte Ma	Be Com	Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Las	College (1-4or 5+)	HOME MAKER	other's Name (First, Middle, I	OWN HOME Maiden Sumame)						
and Mental is marked c	To B	DONALD TERRY  19a. Informant's Name/Relationship	(Type, Print) 19	FL b. Mailing Address (Street and Nu	ORENCE BRANHAL							
f Heelth ar item 27 is other treu		LINDA C. HIGGS  20a. Method of Disposition	DAUGHTER 20b. Place	625 DONALDSON A of Disposition (Name of	VE. SEVERN, M							
ry or		Burial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Special Service Liese)	ify) GLEN		4.4.2006	GLEN BURNIE, MD						
Departm Importe any inju		K GREGORY FAN			Y SW GLEN BUR							
physicien and stransit and stransic and stra	dicai Examiner	resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence  b. Due to (or as a consequence  c.  Due to (or as a consequence  d.	of: infavetion								
e ettending id for use a	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year						
een signed by the encould be detached to	d by Pi	Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause given in Pa		bacco use contribute to the cause of death es 2 □ No 3 □ Probably 4 Dunkno						
ete has b page 2 sh	Completed	).			24a. Was a autops perfor	by prior to completion of cause						
this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4	lace of Death (Check only on Nursing Home 5 Reside	ence 6 Other (Specify)						
death. stor: After the funera	ication:											
9 5 0	Certi	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  28f. Location (Street and Number or Rural Ros City or Town, State)										
nersi Dir filled in	<u>a</u>	29a. Certifier 1 Certifying P			de ette e e e e e e e e e e e e e e e e	-1 d -1 d d 1- 1b (-)						
ithin 24 hours aft o the Funeral Dis ompletely filled in	Medical Certification:	29a. Certifier (Check only one)  1 Gentlying P 2 Medical Exa 29b. Signature and title of certifier	miner: On the basis of examination a and manner stated.	29c. License numb								
within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	Medical	(Check only 2 Medical Exacone)  29b. Signature and title of certifier	miner: On the basis of examination a	29c. License numb	er 2	9d. Date signed (Month, Day, Year)  Acreh 3   20006  A 20001						

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** JANET R. BEARRY MARCH 31 2006 10:30a<sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE RUXTON TOWSON BALTIMORE If Under 1 Year Months Days 8. Date of Birth 06/12/1924 5. Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min MARYLAND 1 ☐ M 2 🖫 F 217-20-4054 81 Director Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Heelth and Mental Hygiene. and the file and 27 is marked other than "natural", or Items 23a or 28a-f show mut; if item 27 is marked other than "natural", or other traumatic event, its Medical Exercise mutal the notified at ury or other traumatic event, its Medical Exercise mutal the notified at 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 1 Yes 2 No Director BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 N. CHARLES ST. 21204 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify. Š 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12YRS College (1-4or 5+) SALESPERSON SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD L. RECKORD BEULAH COCKEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEOFREY SCHENKEL(SON) 4169 NORRISVILLE RD. WHITE HALL, MD. 21161. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. GREEN MOUNT CREMATORY04/04/06 BALTO. CITY, MD. 21. Signature of Fuperal Service Licenses 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO.
16924 YORK RD MONKTON, MD. 21111. Wills Callet 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown ģ s been signed be should be determined by the statement of the signal of Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 : certificate 2 No 1 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient Ē 3 DOA this After th 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 Yes 2 No i Director: / d in by the f investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide within 24 hours of To the Funerel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Mohth, Dav. Year) in 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6331 152 WONG 2. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 4 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 115 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 28, 2006 Doris Linwood Burton /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Lorien Nursing Home Columbia Howard 8. Date of Birth (Month, Day, Year) Aug. 31, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F Months Days Hours Min 69 Yrs 1936 Director 212-32-9196 Maryland Usual Residence of Decedent death with the Maryland 10b County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f ahow other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 🏋 ☐ No MD Baltimore Director Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 4230 Hollins Ferry Rd., Apt. 215 or iteme 23a 21227 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after de ital Hygiene. Id other than "natural", or Item Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates: Specify. 3 → Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: if Item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Robert Alexander White 2 Evelyn Louise Engles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Preston Burton, Son 7621 Bear Forest Rd., Hanover, MD 21076 20b. Place of Disposition (Name of Mead Owl Tidge 20a. Method of Disposition Date 20c. Location - City or Town, State X Gurial 2 ☐ Cremation 3 ☐ Removal from State Apr. 3, 2006 Elkridge, MD 4 □ Qonation 5 □ Other (Specify) Mexflorial Park 22 Name and Address of Facility Ambrose Funeral Home, Inc. 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestive heart Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hrmic renal Sequential / list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to jor as a consequence of Examiner be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of) the attending physicien Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ğ Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. P 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 90 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2. No 1 Tyes 1 Yes Hospitel or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D005370 9 3 30 2006 ou un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAWUT Challan lane STE # 210 KAJ 14300 Bowie MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature 20713 State Registrar APR 0 4 2006

			For State Registrar	State of	Maryland		artment rtificate		lealth and l Death	Mental Hy	giene Reg. No.	006	• 0	282
- 1	Physicia		1. Decedent's Name (First, Middle,	Last)						2. Date of Do Month	eath Day	Year	3. Time (	
	/Medic	al	Leona J. Bang		-					March	31	2006		) A <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution, g	rive street and numb	er)				Location of Deat	1	4c. Co	ounty of Death		
			Wesley Home  5. Social Security Number 6	. Sex 7.	Age (In yrs. Ia	ast birthday)	Balt If Under		re If Under 24 Hrs.	8. Date of Bi	n/		place (State	or Foreian
	Funeral Director		218-14-8613	1 M 2 F	89	Yrs.	Months	Days	Hours Min.	Aug. 3	ay, Year)	MD	ntry)	
			Usuel Residence of Decedent							nug.	1310			
	how		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside (	-
	Ba-f a	Sch	MD Baltim	ore		Timon	ium							s X No
٩	or 20	Director	10e. Street and Number				10f. Zip	Code			-	n of What Cou	intry?	
8	death with the Maryland ms 23a or 28a-f ahow rmust be notified at	20	221 East Timon					1093			US		and Indian	
13	ttem ttem	un.	<ol> <li>Marital Status</li> <li>Never Married 2 Married</li> </ol>	12. Was Decede	es?	5. 13.	rvas Decedi If Yes, spec	fy Cuba	ispanic Origin? (S an, Mexican, Puer	lo Rican, etc.)	14	Race - Amer Black, White		
7 3 <b>8</b>	a 0 5	by	3 X Widowed 4 □ Divorced	1 □ Yes 2 If Yes, Give Year or Date	^		1 🗌 Yes 2	<b>X</b> No	Specify:		S	pecify: V	vhite	
J . 2	"natural",		15. Decedent's			16a. Deced	dent's Usua	Occupa	ation	dia -	16b. Kind	of Business/I	ndustry	
36.02		De l	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	e retired	during most of wo. d)	King				
<b>5</b>	Hygien Hygien Ather th	Completed	12	n/a_		Billi	ng_Cl	erk				Insur	ance	
25C	be fit H d oth	Be	17. Father's Name (First, Middle, La Andrew Perry	ist)					18. Mother's Nar		e, Maiden St	ımame)		
Leon社 Maryland	Men Men arka	၉						42.	Helen					
Mar	0 4 5 5	ĺ	19a. Informant's Name/Relationship	, , , , ,			-		and Number or Ri					
* Silven	s 1 and of Health itam 27 other tr	J	Patrick Bangs/ 20a. Method of Disposition	son	20b. Pf	ace of Dispo	sition (Nam	e of	nium Rd	Date Timo	nium, 20c. Loca	MD 21 tion - City or T	own, State	
Po Po	00		1 Surial 2 Cremation 3		ate	metery, crer	-		1 4 / 4 /	06 28dope				
Baltimore,		İ	4 ☐ Donation 5 ☐ Other (Special Service) kin		Dui				emorial C					
20 B	permit Departm Importe any inju		1 Milli	emmon	my		emmor	า Fu Pado	ss of Facility uneral Ho onia Rd.	ome of I	Dulane	y Vall	ey, Ir	ic.
		Î	23a. Part1. Enter the disease, or co	omplications that cau	sed the death	. Do not ent	er the mode	of dyin	g, such as cardia	or respiratory a	arrest,	NID ZI	Approxima Interval Be	at <i>e</i>
	Physician		shock, or heart failure. List or Immediate Cause (Final	,		- M	11171	TN	r. 005	Dimia	1714		Onset and	Death
0	/Medical		disease or condition resulting in death)	Due to (or	as a consequ	ence of):	UL/1-	LNI	FARCT	Demen	////	-	TENFIC	-2
150	Examiner		Conventingly list conditions	, CERL	as a consequ	ASCU	ILAR	i	DISEAS	2			YEAR	کہ
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	ence of):			•				1-	
	acute ind trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	· HTPE	RTENS	IVE	CAL	2010	VASCU	LAR 1	PISEA	56-	YEAR	. ک
90,	be executed sicien and burial-transit	ũ	resulting in death) cast	Due to (or	as a consequ	ence of):								
8760,	physic	dlca		d										
9 X	The law requires thet the death certificate be executed sie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outco	me of pregnar	ncy					23	d. Date of delin	erv	
Вох	atter for u	clar	23b. Was decedent pregnant in the past 12 months?		h 2 ∏ Fetal nt at time of de		Ectopic pre Other (spe		′			Month	Day	Year
P.O.	the d yy the achec	hys	1 □ Yes 2 X No 9 □ Unknown	9□ Unknow	m									
	res thet the de igned by the a be detached to	by P	Part II. Other significant condition	s contributing to dea	th but not resu	lting in the u	nderlying ca	ause give	en in Part I.	23e. Did	tobacco use	contribute to	the cause of	death?
퉏	w require been sig should b									10	Yes 2	No 3∏Pro	bably 4	Unknown
8	aw re	Completed								24a. Was		24b. Were aut	opsy finding	s available
æ	The lav	E O							-	perf 1 ☐ Yes	ormed? 2X No	death? 1 ☐ Yes		04435 01
ita	certificate rector, pag	Bec	25. Was case referred to medical examiner?	1					26. Place of De	ath (Check only	one)			
<u></u>	W 10 ==	2	1 ☐ Yes 2 No	Hospital: 1 1 1np		ER/Outpatier			4 Nursing F	lome 5□Res			ify)	
n c	ding Phy h. After this funeral c	ö	27. Manner of D ath  1 Natural 5 □ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Bc. Injun Worl		28d. Describe how injury occurred				
sio	Attending r death. ector: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	the -	f being At he		М		Yes 2 □No	28f. Location	(Ctropt and	Vienber Di		
Division of Vital Records,	2 th 2	Certification:	4 ☐ Homicide determin	ad 288. Place o	f Injury - At ho , etc. (Specify		reet, factory	, опісе			(Street and I wn, State)	Vu <i>mber or R</i> u	rai Houte Nu	mber,
ليما	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by		29a, Certifier 1X Certifying	Physician: To the b	est of my know	Whatche ideall	h accurred a	at the far	me. "late and prace	and due to the	cause(s) or	nd manner as	statad	
	e Ho: 24 h e Fur letely	edical	(Check only 2 Medical E.	caminer: On the bas and manne	is of examinat	ion and/or in	vestigation,	in my o	pinion, death occi	arred at the time	, date and p	ace, and due	to the cause	(s)
	To the Hospital within 24 hours a To the Funerei Completely filled	Me	29b. Signature and title of certifier	<u> </u>			29c	. License	e number		29d. Date	signed (Month	Day, Year)	
	-/		Kohert E.	. Volus_	M.D		7	) - /	9425		3/3	1/200	6	
	nay	1	30. Name and address of person w	no complet voluse	of death (Item	23a) (Type,	Print)			^	1	1-000	*	0
_0	L		ROBERT E.	ROBY M	D 2	211 N	I. ROC	TER.	S AVE-	BALTIM	ORE.	MD "	2120	1
	Sta		31. Date filed (Month, Day, Year)	32. Reg	strar's Signat	ure	Sparke	1						
	Registr	3F	APR 0	4 / 1000 12	TO CAR	10 P	97							

	_	State Registrar	State of Marylan	•	artment of H		R	eg. No. UU6	10283
Physicia /Medica Examine	al -	Decedent's Name (First, Middle, Last)     Babette Rohmer I     Aa. Facility Name (If not institution, give st     Upper Chesapeake	reet and number)		4b. City, Town, or Belair	r Location of Death	2. Date of Deal Month MARCI	Day_ Year	th
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. <b>79</b>	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March	9. Bi 28 1927	thplace (State or Foreign ountry) MD
filed within 72 hours after death with the Maryland Hygiene. sther then "natural", or iteme 23a or 28e-f ehow ant, the Mazical Examination to inclined at	ector	10a. State 10b. County  MD n/a		y, Town or Lo Baltimo	re				10d. fnside City Limits 1√2 Yes 2 □ No
eath with t	Funeral Director	3501 St. Paul St.  11. Marital Slatus	Apt. 1104 2. Was Decedent Ever in U.	S. 13.	10f. Zip Code 21218 Was Decedent of H	lispanic Origin? (Si		Og. Citizen of What CUSA	
ours after d ral', or iten Evarinal	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No ff Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Rican, etc.)	Specify: W	
within 72 ho ene. then "natu he Medical	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	ation completed)  College (1-4or 5+)  n/a	(Give life.	dent's Usual Occup kind of work done o DO NOT use retired <b>kkeeper</b>	durina most of wor.	king	16b. Kind of Business  Construct	
o d a b	To Be C	17. Father's Name (First, Middle, Last)  Henry Adam Rohm					y Kenne	Maiden Sumame)	
1 and 2 sho Heelth and I am 27 ie my ther traums	33	19a. Informant's Name/Relationship (Typ William C. Bafford 20a. Method of Disposition	l/son	138	05 Prince	ess Anne	Way, P	n, City or Town, State,  hoenix, M  20c. Location - City o	D 21131
permit. Pages Department of Importent: If It eny Injury or o once.		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of prenal Service 100	moval from State	uid Ri	osttion (Name of matory or other place dge Cem  2. Name and Address	4/3/0		Pikesville	
bur be	dicai Examiner	fmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, an any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence to (or a))).	uence of):	TESTÍNA	L BLEE.	DING		Onset and Death
To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Fete 4 Pregnant at time of d 9 Unknown	Ideath 3	☐Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	v Day Year
w requires that to been signed by should be detail	ompleted by Ph	Part II. Other significant conditions cont  PNEUMONIA; (1:  RHEUMATOID ART	PRONIC OBSTR						o the cause of death?  robably 4 CUnknown  utopsy findings available
on: The law	e Comp	25. Was case referred to medical	HK1 1 1 S			26 Place of Dea	autops perforr 1 Yes	sy prior to med? death? 21 No 1 □ Ye	completion of cause of
ding Physicien: The After this certific funeral director,	To B	examiner?  1 Yes 2 No Ho  27. Manner of Death  1 Natural 5 Pending	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpaties 28b. Time o Injury	f 28c. Injur Wor	er: 4 🗆 Nursing H	ome 5 Reside	ence 6 Other (Spoow injury occurred	ecify)
itel or Attendins after deather Insertor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st			28f. Location (Si City or Town	treet and Number or F n. State)	lural Route Number,
To the Hospitel or At within 24 hours after or To the Funerel Direc completely filled in by	Medical	(Check only 2 Medical Examinione)	cian: To the best of my knoer: On the basis of examina and manner stated.	wledge, deat tion and/or in	vestigation, in my o	pinion, death occu	rred at the time, d	ate and place, and du	e to the cause(s)
or Twith	4	29b. Signature and title of certifier  Mellieur	The second secon	226\ /T -	29c. Licens	5344		9d. Date signed (Mor	
Stat Registra		30. Name and address of person who son  SURESH DHANTANI  31. Date filed (Month, Day, Year)  APR 0 4. 201	40 6225. U 32. <b>F</b> egistrar's Signa	NION A	WE, HAY	RE DE GR	ACE NO	21078	

# 800453132

			riease	State of Marylan						_	JiDic.	
		•	For State	State of Marylan	•	rtificate of				leg. No:	06	10284
			Registrar  1. Decedent's Name (First, Middle, Last	)				2.	Date of Dea	ith		3. Time of Death
	Physicia		Wilson P.	Billings	ley			Ma	Month arch	29, 2	Year 2006	1:55A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	8	4b. City, Town, o	r Location of				nty of Death	1 10001
		•	Long View Nursing	Home		Manch	ester				Carro	
	Funeral		5. Social Security Number 6. Se		• •	If Under 1 Year Months Days	If Under 2 Hours	Min. 8.	Date of Birth (Month, Day	r, rear)	9. Birth	place (State or Foreign
н	Director		220-07-1965	84	Yrs.			A1	ug. 12	,1921		MD
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation		-				10d. Inside City Limits
	Many fied a	호	MD Balti	more	Re	isterstow	m					1 ☐ Yes 2X No
	r 28a	Director	10e. Street and Number			10f. Zip Code				10g. Citizen o	of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show rnust be mulfied at		304 Cantata Cour	t Apt 112			21136				USA	
	ems ems	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Orig an, Mexican,	gin? (Specify , Puerto Ric	y Yes or No- an, etc.)	14. R	ace - Ameri lack, White,	
20	hours after tural', or Ite	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🕱 No	Specify:			Spec		hita
-000-	in 72 hours after death with the Marylan "naturial", or flems 23a or 28a-1 show tadical Examiner must be notified at		15. Decedent's Edi		16a. Dece	dent's Usual Occup	ation		- I	16b. Kind of		hite dustry
<u> </u>	n "nat	piet	(Specify only highest grad	de completed) College (1-4or 5+)	(Give	kind of work done  DO NOT use retire	<i>duri</i> ng most d)	of working				
7	d withir giene. er than	Completed	12		A	uto Mecha					tomob	ile
	be filectal Hyg	Be (	17. Father's Name (First, Middle, Last)							Maiden Sum	ame)	
ylan	D & 8 C	၉	Alexander Graham						Bryso		21.1.7	0.11
Jar	d 2 shoulth and Mills is mark		19a. Informant's Name/Relationship (T			ing Address (Street						Code)
ຍ໌ ອ	s 1 and f Health itam 27 other t		Carol L. Baldwin  20a. Method of Disposition	Daughter 206.	Place of Disp	ailroad A		Date		20c. Locatio		own, State
5	8 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	•	matory or other play Forest Ve		4/4/	06	Orrin	oca Mi	11s, MD
	artmen ortant: injury e.		21. Signature of Funeral Service Licen:			2. Name and Addre		-				town Road
Balt	permit. F Departm Importar any injur		13 8	Elmi	E	line Fune	eral H	ome				MD 21136
			23a. Part 1. Enter the disease, or companion, or heart failure. List only	lications that caused the dea	th. Do not en	ter the mode of dyin	ng, such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between
ř	Physician	/	Immediate Cause (Final	acute	Con	mary,	Ry	ndr	me			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	, 8	8,				,	+ 1
	Examiner		Sequentially list conditions,	b. Due to (or as a consec	ary	avar	y a	role	role	-en	as	lage.
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dub to (or 23 2 consec	dagico 60.		U					O
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a consec	quence of):							
9		call	(	d								
8	The law requires that the death certificate ate has been signed by the attending phy page 2 should be detached for use as the	Medi	IF FEMALE:									
X R R	ath ce ttendii	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	□Ectopic pregnanc	у				Date of deliv Month	ery Day Year
0	the a	Completed by Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of a 9☐Unknown	death 5	Other (specify) _				ļ.		
7	w requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions of	ontributing to death but not re-	sulting in the	underlying cause giv	ven in Part I.		23e. Did to	obacco use co	ontribute to	the cause of death?
g.	uires sign lid be	d b							101	res 2 No	3 □ Pro	bably 4 □Unknown
င္ပ	beer s peer s	lete							24a. Was	an 24	b. Were aut	opsy findings available ompletion of cause of
ž	The la	mo.							perfo	rmed?	death?	2□ No
Vital Records,		BeC	25. Was case referred to medical examiner?					of Death (	Check only o	ne)		
>	Physic this ceral dire	ို	1 Yes 2 No		ER/Outpatie	ent 3 DOA				dence 6 🗆		ify)
Ĕ	Ing P	in o	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wo	ryat rk? ]Yes 2 ⊡1		a. Describe r	now injury occ	currea	
Division of	death ctor: / the 1	icat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be		nome, farm, s				f. Location (S	Street and Nu	ımber or Rui	ral Route Number,
2	after after Dira	Certification:	4 Homicide determined	building, etc. (Spec	ify)	,			City or Tov	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Diractor: After this certificy completely filled in by the funeral director,		29a. Certifier 1 CertifyIng Ph	ysician: To the best of my kn niner: On the basis of examin	owledge, dea	th occurred at the ti	me, date an	id place, and	d due to the	cause(s) and	manner as	stated.
	the Hin 24 the Fu	Medical	one)	and manner stated.	ation and or i	29c. Licen			4 (110 (11110)	29d. Date sig		
<b>\</b>	To Toon	2	29b. Signature and title of certifier	O. hora	701			50%				/
	1/1		Thale	- rycery	7	Print)	0010	06		3/2	1/0	6
1	17		30. Name and address of person who	JOVER IN K	mi zda) (Type	MANCHE	STER	MI	0 21	102		
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	/ (///- W/L	J U - / C	7				
	Regist		APR 0 4 2	0006	K A	harde d						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No.UU6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1:50 PM April 2,2006 HERMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Timonium Baltimore Stella Maris If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 22, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1XM 2□ F 213-03-9121 93 Vrs Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 🛣 No MD Baltimore Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9802 Magledt Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑X'es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Drywall & Plaster Com. Contractor 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental int: If item 27 is marked c John Scott Bell Martha Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara A. Van Horn-daughter 9802 Magledt Road-Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition Evans Funeral Chapel Air 4-4-06 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 0 permit. Page Department of Important: If ony injury or once. Forest Hill, Maryland 22. Name and Address of Facility EVANS CHAPEL OF MEMORIES 21. Sign were of Funeral Service Licensee 8800 Harford Road-Parkville, MD mone tudo 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ⋈ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 Other (specify) be detached o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performed? certificate 2 No 1 Yes 2 No 1 Tes of Vital Be 25. Was case referred to medical 26. Place of Death Check only one Other: 4K Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Division 1 Statural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number of mesting 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD ERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State APR 0 4 2006 Registrar

**Physician** 550 W ONAS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locatio Examiner Oak Crest Care Center Parkville If Under 1 Year If Und 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days **1**∕ M 2 □ F 94 112-24-0174 Yrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location sr then "natural", or items 23a or 28a-f show the Medical Examinat must be nutified at MD Baltimore Parkville Completed by Funeral Director 10e. Street and Number 10f. Zip Code 3:55Am 8810 Walther Blvd., Apt. 1528 21234 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic If Yes, specify Cuban, Mexic 11. Marital Status 1 ☐ Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Speci 3 ☐ Widowed 4 ☐ Divorced BASSEN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Branch Chief/Requ 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fith Department of Health and Mental Hy Important: If Item 27 Is marked oth any july or other treumatic event 2008. Be PANSI Bassen Hvmen ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num 8810 Walther Blvd Lillian Bassen=wife Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Serv. Corp \*4 ☐ Donation 5 ☐ Other (Specify) William G. Dau 21. Signature of Funeral Servic Licensee 22. Name and Address of Fac 1050 York rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final DUSMANIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner rsicien and e burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ng physi IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant atten for u 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa Be Completed by

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

For State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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not institution, give		ber)		4b. City,	Town, or	Location of	of Death		40	. County of		
st Care C	enter				rkvi					Balt	imore	
174 Se	X 7	. Age (In yrs. Ia 9 <b>4</b>	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir Nov . 5	th ay, Year	11	9. Birthplace (S Pennsy]	
Decedent 10b County		10- 0"	Tour	- 141.00							1.2	
10b. County Ba	ltimore	10c. City,	Park									ide City Limits Yes 2 No
nber				10f. Zip	Code				_		nat Country?	
ther Blvc	i., Apt.	1528			2123	4				U.S.A	١.	
	12. Was Deced Armed Ford	ces?	. 13. V	Vas Deced Yes, spec	lent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	o-		- American Indi , White, etc.	ian,
ed 2[XMarried 4 Divorced	1 🗍 Yes 2 If Yes, Give Year or Dat	¥ No		I□Yes 2		Specify:		,		Specify:	White	3
15. Decedent's Ed ify only highest grad	ucation de completed)		16a. Deced (Give	kind of wor	k done d	uring mos	t of work	ing	16b. K	ind of Bus	iness/Industry	
ndary (0-12)	College (1-4	4or 5+)	life. L	oo NOT us ch Ch	e retired,	)			F	edera	al Gove	rnment
First, Middle, Last)						18. Mothe	r's Name	e (First, Middle	, Maider	Sumame,	)	
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me/Relationship (7	ype, Print)										tate, Zip Code)	
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osition Cremation 3   5  Other (Specify		tate Cer	ice of Dispo metery, cren top St	natory`or ol	ther place		1/1/	Date	_	ocation - C	City or Town, Sta	ate
neral Service licen		am G. D						ck Tows son, MD		unera 204	al Home	, Inc.
ne disease, or comp t failure. List only of Final n nditions, mediate	a	ch line.	NE U				cardiac (	or respiratory a	rrest,		Interv	oximate al Between t and Death
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pregnant months?		th 2 ☐ Fetal on the attime of dea	death 3	Ectopic pro						23d. Date Mont	of delivery h Day	Year
icant conditions co	entributing to dea	ath but not resul	ting in the ur	nderlying ca	ause give	en in Part I		23e. Did	tobacco	use contrib	oute to the caus	se of death?
dem	ient	~		, , ,					Yes 2		B Probably	4. Onknown
								24a. Was auto perfe 1 \( \text{Yes} \)		pri	ere autopsy fine ior to completio eath?	n of cause of
red to medical						26. Place	of Deat	h (Check only				
No	Hospital: 1 ☐ In	patient 2 🗆 E	R/Outpatien	t 3 🗆 DO	Othe	or /		me 5 Resi		6 Other	(Specify)	
5 Pending investigation	28a. Date of (Month)	f Injury , Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe				
6 Could not be determined	28e. Place o	of Injury - At hon g, etc. (Specify)	ne, farm, str	eet, factory	, office			28f. Location ( City or To	Street a	nd Number e)	r or Rural Route	e Number,
1 Certifying Phr 2 Medical Exam	ysician: To the b liner: On the bas and manne	sis of examination	rledge, death on and/or inv	occurred vestigation,	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s date an	) and mani d place, an	ner as stated. nd due to the ca	ause(s)
title of pertifier	) \ \	1 / 1	IN	29c	. License	number	24	2	294. Da	ite signed	(Month, Day, Y	(ear)
ess of person who	completed cause	of death (Item	23x) (Type,	Print)	را سار	al Tr	121	blul	)	lant	Lville	Mdizu
th, Day, Year) PR 0 4 20	pio .	gistrar's Signatu	TLE TE	2300		101						2(6) 7
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Reg. No.

Day

Year

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2. Date of Death

Month

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within 24 hours aft To the Funerel Di completely filled in

State Registra

P

Certification:

Medical

25. Was case referred to medical

1 ☐ Yes 2 ☐ No

27. Manner of Death

Natural

2 Accident

4 Homicide

(Check only one)

DAUCE

29b. Signature and title of pertifier

3 Suicide

29a. Certifie

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month 50 30 - 06 **Physician** BUKOSKY WELENA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE TOWSON CARE MAUDR If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth OCT. 16, 1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 25√F 83 Yrs. 216-14-7213 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10h Counts r then "natural", or items 23e or 28e-f show the Medical Examiner roust be notified at 1 □XYes 2 □ No BALTIMORE **Funeral Director** MD. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21224 607 TOLNA STREET U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hiem: If Item 27 is marked off MICHAEL NICHOLAS BLAMA ANNA KOVIAK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Heath ar
Importent; If Item 27 is
any injury or other trau 41 BRUCESTER BRIDGE CT., BALTIMORE, MARYLAND 21228 ANN PIETROWIAK/DAUGHTER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4/3/06 BALTIMORE, MARYLAND HOLLY HILL MEMORIAL 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service License 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 laberer 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause to each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years )ementia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by Ischemic 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 100 autopsy performed 2,010 2 No 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2. To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D006119 Mar, 31, 2006 29/2 Oi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) st, Suite 209, Touson, MO 21204 6565 North Charles Black . Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 4 2006

			State of Maryland / Department of Health an Certificate of Death		ene g. No. 006 10289
:	Street.		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year
	Physic /Med		Carolyn Clara Cline	March 3	0, 2006   12:30 A M
	Exam	iner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D	Death	4c. County of Death
			Joseph Richey Hospice  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday) If Under 1 Year   If Under 24	Hrs. 8. Date of Birth	N/A
	Funera Directo			Min. (Month, Day,	Year) 9. Birthplace (State or Foreign Country) 1922 Maryland
		9	Usual Residence of Decedent	Trust 49	
	larylan ehow	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	% W W	ecto	Maryland Baltimore Baltimo		1 ☐ Yes 2 ☐ No
	IG after deeth with the Maryla or Iteme 23e or 28e-f ehor	Funeral Director	10e. Streel and Number 10f. Zip Code	1	Og. Citizen of What Country?
	leeth	era	2725 Arbutus Avenue 21227  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin		USA 14. Race - American Indian,
	iffer d	FI	Armed Forces? If Yes, specify Cuban, Mexican, P  1 Never Married 2 Married 1 Yes 2 No	uerto Rican, etc.)	Black, White, etc.
Š	ours a	1 by	3 □XWidowed 4 □ Divorced If Yes, Give Year or Dates:		Specify: White
L.	72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	working 1	6b. Kind of Business/Industry
Š	within the same.	D D	Elementary/Secondary (0-12) College (1-4or 5+)		O II
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	Maryland 21215-0036 d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. 77 ie marked other then "satural", or Items 23e or 28e-f show treumatic event, the Medical Examinar must be notilised at	To Be	George Erbe	latilda Johr	nson
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	re, M s 1 and 2 r Health tem 27 other tre		Marilet S. Baker/Daughter 3204 Gorham Court B		
33	\$ 50 = 0		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State	Date 2	Oc. Location - City or Town, State
38	timen timen tant:	1	4 □Donation 5 □Other (Specify) Metro Crematory, Inc. 3		Baltimore, MD
0	Baltimo permit. Page Depertment of Important: If eny Injury or		Thomas that		Society of MD, Inc.
10			Edward A. Gregorchik 299 Frederick Ro 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car		st. Approximate
	Pnysician		shock, or heart failure. List only one cause on each line.	cceas	Interval Between Onset and Death
	/Medica		disease or condition resulting in death)  a	co de los	1 main
	Examine		Sequentially list conditions b.		
2	D iii	iner	Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury		
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200	8 760, rate be executed physicien and the burial-transit				
36	687 ilicate g phys	edic	G.		
8	OX 68 h certific anding p	N/S	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of delivery
. ) [	VISION Of VITAL HECOTOS, P.O. BOX 68/6U, Attending Physician: The law requires that the death certificate be executed reasth.  reasth.  reter: After this certificate has been signed by the attending physician and ythe funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical	in the past 12 months?  1		Month Day Year
\ 6	that the ded by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22a Did tab	A STATE OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF T
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O:	tal an: T tificete tor, pa	40	25. Was case referred to medical 26. Place of	Death // Check only one	No 1 Yes 2 No
	T VIII	To B	examiner?	ng Home 5 Resider	e That I sall o.
5	on of		27. Mapner of Death 1. Natural 5 Pending (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe how	w injury occurred
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5	DIVIS to Att after d Direct	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
3	Hospital 24 hours a Funeral C	S	29a. Certifier 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	Jaco and due to the co	
C	중 수 및 등	edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death one)	occurred at the time, da	te and place, and due to the cause(s)
_	To the within 2 To the complet	¥ Me	29b. Signature and title of certifier 29c. License number	29	d. Date signed (Mointh, Day, Year)
			Jeellungeran (1 m) D334-00	6	03/30/2006
	5T		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  THEVELL WIGGENART TILMS (320) N CHARUS S	FT BAIDIM	06 MD 21212
	S Regis	tate trar	31. Dale filed (Month, Day, Year)  APR 0 4 2006  32. Registrar's Signature		

or Attending Physician: The law requires that the death certificate be executed Box 68760. o <u>م</u> Division of Vital Records, s after de-rat Director: Alte To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by ti

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After

**Funeral** 

Director

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28a-f

23a or

or Items

**Physician** 

/Medical

Examiner

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner must be notified at

State Registrar

APR 0 4 2006

LOUIS LARCA 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUENUE,

			Please	e Type or Prin					•	_	
			For	State of Ma	aryland /	-			Mental Hyg	iene	10201
			State Registrar			Cer	tificate of l	Death	Re	g. No.	10271
	Physici:		1. Decedent's Name (First, Middle, I	ast)					2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic		Vernon	н.			Cronha	rdt	March	31,2006 Year	6:20 PM
	Examin		4a. Facility Name (If not institution, g					Location of Death		4c. County of Dea	
		30	Riverview Nurs				Esse		1	Baltim	
- 1	Funeral Director		212-10-9360	Sex 7.Ag	e (In yrs. last b	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, January 2	8, 1914 Mar	thplace (State or Foreign punity) Yland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation				10d. Inside City Limits
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "neturel", or Items 23e or 28e-1 show or other traumatic event, the Medical Examinar must be notified at	ō	Maryland Baltim	ore	Dunc						1 ☐ Yes 2X No
	r 28e	Funeral Director	10e. Street and Number	OF C	Durc	MALIN.	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	136 or	O IE	2523 Liberty Pari	kway			21222			USA	
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Spanic Origin?)	pecify Yes or No-	14. Race - Ame Black, Whit	
9	or Ite		1 Never Married 2 Married	1 ☐ Yes 2XX	No	1	I ☐ Yes 2 🕱 No		o i noun, etc.,	Casait.	
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7	n 72	Completed	15. Decedent's (Specify only highest)	Education grade completed)	168	a. Deced (Give life. I	lent's Usual Occup kind of work done o DO NOT use retired	ation during most of world d)	king	16b. Kind of Business	Industry
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an	id be ental ked c	To Be	Raymond Cronhard	t				May Cro	onhardt N	Jickel	
ary	shou ind M mar umat	-	19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailin	g Address (Street			City or Town, State, .	Zip Code)
ž	alth a straight a straight trains		Eileen Cronhardt	daughter					Dundalk	,Maryland	21222
ore,	of He of He litem		20a. Method of Disposition	□Bomoval from State	20b. Place cemet	of Dispo ery, cren	sition (Name of natory or other place ge Cemete	a) Apr	il 5,	20c. Location - City or	Town, State
<u>Ĕ</u>	Pages ment of H ent: If its ury or of		1 🄀 Burial 2 ☐ Cremation 3 • 4 ☐ Donation 5 ☐ Other (Spe		Meadov			4	006	Halethorpe	
Baltimore, Maryland 21215-0036	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Lic	censee /	1	Ĉ.	Name and Address	ss of Facility Uneral H	ome Of D	undalk,P.A undalk,MD.	•
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			23a. 1 rt1. Enter the dise 1 or co shock, or heart failur : ist or Immediate Cause (Final		th deth. Do	not ente	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence	e ot).	Cardi	0			1-270
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence	e of):					
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0,	e be executed sician and e burial-transit		resulting in death) Last	Due to (or as	a consequence	e of):					
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Box 68	The law requires that the death certificate the has been signed by the attending physbage 2 should be detached for use as the	Physiclan/Medl	IF FEMALE:	22a If you cutooma	of propped	-		1000-1			
Bo	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal deat		Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	time or death	5	Other (specify)				
<u>م</u>	that t	/ Ph	Part II. Other significant conditions	s contributing to death b	ut not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds	uires sign ld be	d by	Alzhein	with	disc	90	L, C	080,	1 □ Ye	s 2□No 3□F	robably 4 Unknown
00	w req	lete	Hubel	Mi Ara	,			,	24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
Re	The law ate has page 2:	Completed	- Officer	10000					autops	ned?   death?	completion of cause of
tal		a)	25. Was case referred to medical					26. Place of Dea	1 ☐ Yes 2 th (Check only on		2 2 140
<u> </u>	ysicien: is certific director,	O B	examiner? 1 🗆 Yes 2 🔄 No	Hospital: 1 Inpatie	ent 2 🗆 ER/C	Outpatien	t 3 DOA Oth			nce 6 Other (Spe	city)
0	iding Phys th, After this funeral di	n: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b.	Time of	28c. Injur	y at		w injury occurred	
<u>Ö</u> .	endir sath. or: At he fu	atlc	2 Accident investigation	tion			M 1 🗆	Yes 2 □ No			
Division of Vital Records, P.O.	or Att fer de lirect n by t	Certification:	3 Suicide 6 Could no 4 Homicide determine	286. Place of Inf	ury · At home, f c. (Specify)	farm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	pitel ours a seel E		00.0.00								
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	or my knowledg f examination a ated.	ge, deatr ind/or in	restigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	iuse(s) and manner a ate and place, and du	s stated. e to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c. Licens	e number	2	9d. Date signed (Mon	h, Day, Year)
	F 5 F 0		Mae	W.D.			D.	-387	54	03-31	-2006
			30. Name and address of person wh	no completed cause of c	leath (Item 23a	) (Type.	Print)		1	1 4 5	1001
	Į		MALIKA L	NASBEM	. 70	9.	BASTE	BRN 1	SLUD.	MD -	stated.  to the cause(s)  th. Day, Year)  2006
• 0	Sta	te	31. Date filed (Month, Day, Year)	32 Registr	ar's Signature	A	A.				
	Registr	ar	APR 0 4 2	UUD JOB SAN	2 15	200					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2006 **Physician** April 1 7:45 A M Cook Florence M. /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Catonsville Catonsville Commons Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 25,1923 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min 1 ☐ M 2 🔀 F 82 Yrs. 218-14-8914 Maryland Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County •how other than "natural", or Iteme 23a or 28a-f ehovent, the Modical Examiner must be nutified at 1 ☐ Yes 2√ No Maryland Baltimore Dundalk Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 USA 1852 Church Road filed within 72 hours after death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any linity or other traumatic event, ang. 17. Father's Name (First, Middle, Last) Ida Wett Frank Resch 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1852 Church Road, Dundalk, Md. 21222 James R. Cook Jr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 4, 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2006 Baltimore City, MD. Bayview Crematory 21. Signature of Funeral Service Licensee <sup>22</sup>Name and Address of Facility Lome Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Set only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MIZHEIMERS Disease many years Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physicien s Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Discone 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown within 24 hours after death.

To the Funeral Director; After this certificate hes been si completely filled in by the funeral director, page 2 should Porkinson 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Miseone 1 Yes 2 🕰 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 4,2006 127541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GETHA RATA MD, 4367 Hollins Ferry Rd, Slite 4A, Baltimare IND 21227. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 4 2006 Registrar

		1	For State - State Registrer	ate of Maryla		artment tificate			nd M		iene	5	0293
	Physici	an	1. Decedent's Name (First, Middle, Last)	Coviello						2. Date of Deat Month April		Year	3. Time of Death 12;15 P.M.
	/Medic Examin		4a. Facility Name (If not institution, give street 607 Blankner Roa			4b. City,		Location o	11e			rro1	
	Funeral Director		5. Social Security Number 6. Sex 1 M		. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Sept. 6	,1942		ace (State or Foreign try) hington D.C
	Maryland e-f show		Usual Residence of Decedent           10a. State         10b. County           Md         Carro1		ity, Town or Lo	cation	Syl	kesvi	11e				0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with th	۵	10e. Street and Number 607 Blankner Road			10f. Zip	2	1784			0g. Citizen of Wh	U	SA
920	within 72 hours after death with the Maryland liene. r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be Indiffed at	by Fur	1 Never Married 2 Married 1	as Decedent Ever in med Forces?  ☐ Yes 22 No Yes, Give ear or Dates:	i	Was Deced If Yes, spec 1  Yes		spanic Oriç n, Mexican S <i>pecify:</i>	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	, White, e	
21215-0036	c * 3	Completed	15. Decedent's Education (Specify only highest grade continued the Elementary/Secondary (0-12) 12 Grade	n npleted) ollege (1-4or 5+)	1	dent's Usua kind of wo DO NOT us	rk doné d se retired	ation during most )	of work	ing	16b. Kind of Bus		Home
Maryland 2	be filed tal Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Last) Raymond T. Tassa					Ju	ne	Carmen	Maiden Sumame		
	and 2 fealth a rm 27 is		19a. Informant's Name/Relationship (Type, F  Joseph A. Coviello  20a. Method of Disposition  1 □ Burial 2 【X Cremation 3 □ Remo	(Husband)	19b. Maili 607 Place of Dispo	B1a: osition (Nar matory or o	nkne ne of other plac	r Rd.	Sy	kesvill	e, Md. 2 20c. Location - C Hampst	21784 City or To	wn, State
Baltimore,	permit. Pages 1 Department of H Importent: If ite eny injury or ot		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	· ·	2:	2. Name ar	nd Addres	ss of Facilit	у	11824	Reister erstown,	stow	m Road
Name of the last	Pnysician /Medical		3a. art1. Enter the disease, or complication shock, or heart failure. List only one call mediate Cause (Final disease or condition resulting in death)	ns that caused the de use on each line.  Therewe	Conc		le of dyin	g, such as	cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a cons									
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	i yes, outcome of prec □Live birth 2 □Fo □ Pregnant at time o □ Unknown	etal death 3	⊒Ectopic p ⊒ Other (s <sub>t</sub>		,			23d. Date Mon		ory Day Year
Δ.	uires that t signed by Id be deta	þ	Part II. Other significant conditions contribu	iting to death but not r	esulting in the t	underlying o	cause giv	en in Part I		23e. Did to	h-a*		ne cause of death?
Records,	The law requir ate has been si page 2 should	Completed								24a. Was a autop perfor 1 Tyes	sy p med? d	Vere autorior to coreath?	psy findings available impletion of cause of
Vital	ysicien: The is certificate hadirector, page	To Be (	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \text{No} \) Hosp	ital: 1 🗌 Inpatient 2	☐ ER/Outpatie	int 3 D	Oth	05		th <i>(Check only on</i>	ne) lence 6 □Othe	er (Specify	y)
ion of	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		2 Accident investigation	Ba. Date of Injury (Month, Day Year)		М		yat k? Yes 2□	No		ow injury occurre		
Division	tel or Atters after de el Directe	edical Certification;	4   Homicide	Be. Place of Injury - A building, etc. (Spe						City or Tow			
	he Hospitel n 24 hours a he Funerel   pletely filled	edical	29a. Certifier (Check only one) Certifying Physicial 2 Medical Examiner:	n: To the best of my line on the basis of exam and manner stated.	nowledge, dea ination and/or i	nvestigation	n, in my c	pinion, dea	nd place, ath occur	red at the time, o	date and place, a	ind due to	o the cause(s)
)	To the within 2 To the comple	Z	29b. Signature and title of certifier B	unt M	0			is number	0		29d. Date signed 4 - 3 -		
	13		30. Name and address of person who complERANC IS BRUN		tem 23a) (Type	o, Print)	215	Bai	ldin	9#104	4, Colu	mb	19.MD
	S Regis	ate trar	31. Date filed (Month, Day, Year) APR 0 4 200	32. Fegistrar's Si	gnature	See all	P			U			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death MARRICH **Physician** MAGE 20 900C /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner baltimor 8. Date of Birth Month, Day Year If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** -9942 Months 3-52 1 M 2 □ F Days Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

Hydiene. 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at 112 Yes 2 □ No Director more 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 USA 121 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. the Madical Examiner 1 Never Married 2 Married 1 Yes 2 | No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White If Yes, Give Year or Dates: Army ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) U.S.Postal Service Sortei permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If Item 27 is marked other the eny injury or other traumatic event, Iha 9008. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be lark 112abeth ည ernon 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) MD ITIMERE CITY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State torest Hill, MD Evans Funeral Chape 5 ☐ Other (Specify) 4 Donation 21. Signiture of Funeral Service License and Crematur and Address of F alternatives Funeral 2325 rd 21093 Moniom 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sm dmon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FFMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has 1 ☐ Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one examine Hospital Other: 1 Yes 2 ٩ 1, Simplient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this I Director: After this id in by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day,

APR 0

4

EEEE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mb

3 Registrar's Signature

			1 - State Amend Item 2: Registrar Item 6 per  1. Decedent's Name (First, Middle, Last)			70470 rtificat	bahb e of L	ealth an Death		Date of Dea	ath	006	3. Time of	95 Death
	Physici /Medic		Carrie Otell	ia Carpen	ter					arch		006 <sup>ear</sup>	7:1	5 An
	Examin	er	4a. Facility Name (If not institution, give st Catonsville Com		ng Ho	meato	onsv					altimo	re	
	Funeral Director		5. Social Security Number 229–20–5596 6. Sex	7. Age (In yrs.	last birthday, Yrs.	Months Months	Days	Hours I	Min.	Date of Birth (Month, Day av 17	h v. <i>Year)</i> v. 191	Cour	lace (State d try) jinia	or Foreign
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or L							1	0d. Inside C	
	the Mar	Director	Maryland N/A	ват	timor	10f. Zip	Code	_			10g. Citize	n of What Cour		2 🗌 No
	ath with		2210 Westwood Av				2121				US	SA		
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene.  any Injury or other traumatic event, the Madical Examinar must be notified at anone.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates:	I.S. 13.	Was Dece If Yes, spe		spanic Origin n, Mexican, P Specify:	i? (Specifi Puerto Ric	y Yes or No- can, etc.)	. 14	. Race - Americ Black, White, pecify: Bla	etc.	
21215-0036	within 72 h iene. then "netu ihe Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8th grade	ation completed) College (1-4or 5+)	16a. Dece (Give life. Cafe		ork done d se retired,	luring most of )	f working			of Business/Innudica		demy
Maryland 2	should be filed and Mental Hyg s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) Unk.					18. Mother's <b>Eula</b>	Day	7				
Man	of 2 should have a should have		19a. Informant's Name/Relationship (Type Wayne Parker/ So		19b. Mail	ing Address Garob	s (Street a	ourt	Bal	timo:	r, City or 1 re, I	Md 212	670)	
Baltimore,	Pages 1 ar nent of Hea ant: if Item ary or othe		20a. Method of Disposition  1 St Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State Ga	Place of Disponentery, creametery, creametery, creametery, creametery, creametery, creameters. Compared to the compared to the	on F	other place ores	1 =	Date /23/	/06	Owi	ngs Mi	lls	
Balti	permit. Departr Importe any Inju		21. Signature Frieral Servey Cense	8	1	22. Name a 5 2 4 0	Rei	sters	towr	n Rd	Balt	is Fun imore,	Md 2	21213
,160,	Physician /Medical Examiner prijal-transit	dicai Examiner	23a Pant. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Security list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	quence of):	c and	Hyp	ertens	je	Nephro	-t	7	Interval Bel Onset and	
.O. Box 68	The law requires that the death certifica Ne has been signed by the attending ph age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	tc. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of a	al death 3	□Ectopic p □ Other (s					23	d. Date of delive Month	-	Year
rds, P.	quires that n signed by uld be deta	þ	Part II. Other significant conditions con	tributing to death but not re	sulting in the	underlying	cause give	en in Part I.				o contribute to t No 3 ☐ Prof		
Il Records,	The law require cete has been single 2 should it	Completed							_	24a. Was autor perfo 1 Yes	osy ormed?/	death?	psy findings mpletion of a 2 No	available cause of
Division of Vital	Attending Physician: The death. ctor: After this certificate y the funeral director, pag	atlon; To Be	27. Manner of Death 1 Matural 5 Pending 2 Accident Investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury		28c. Injun Worl	er: 4 Nursi	ing Home	Check only d 5 ☐ Resid d. Describe I	dence 6	□Other (Speci	y)	
Divis	or At	Medicai Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, s	treet, factor	ry, office		28	f. Location (: City or To		Number or Run	ul Route Nun	nber,
	ne Hospitel 24 hours of Funeral	dical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	owledge, dea ation and/or i	ath occurred investigation	d at the time n, in my op	ne, date and pointion, death	place, and occurred	d due to the at the time,	cause(s) a date and p	nd manner as s lace, and due t	tated. the cause(	s)
7	To th withir comp	Me	29b. Signature and title of certifier	for AH	MA	7 29	D3	6947	2		29d. Date	signed (Month,	Dey, Year)	06
(	(5)		30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type	Print)	der	CK R	a. C	9 tu	yn Cl	signed (Month,	0 2	228
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 4 2006	32. Registrar' Sign	atur	1								

				For State of Marylar  1 - State Registrar	-	irtment of Health and M <i>tificate of Death</i>	lental Hygie Reg.	7 U U b	10296
				Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
		Physici /Medic		Darrell Carver Caldwell			March 28	, 2006	2236 P <sup>M</sup>
		Examin	er	4a. Facility Name (If not institution, give street and number) Upper Chesapeake Medical Center	er	4b. City, Town, or Location of Death Bel Air		4c. County of Death Harford	
	-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthy	place (State or Foreign ntry)
	2.0	Director		241-42-225 <sup>1</sup> \(\overline{\text{SM}}\) \(^{2}\) \(^{\overline{\text{F}}}\) \(^{\overline{\text{76}}}\)	Yrs.	World Day's Trours Will.	Oct. 13,	1929 Nort	ch Carolina
		yland 10w		Usual Residence of Decedent           10a. State         10b. County         10c. Ci	ity, Town or Lo	cation			10d. Inside City Limits
		with the Maryland s or 28a-f ehow	Director	Maryland Harford E	dgewood				1 ☐ Yes 2 No
Pin		filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or itame 23a or 28a-f ehow that the Medical Exert arrivel to mullied at	Dire	804 Greenbriar Court		10f. Zip Code 21040	10g.	. Citizen of What Coul USA	ntry?
		death me 23	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race · Americ Black, White,	
35	36	within 72 hours after death v iene. rthen "naturel", or Itama 23s tre Medicel Exart artifuel.	by Fu	1 Never Married 2 Marned 1 Yes 2 No	1	☐ Yes 2√2 No Specify:	Moan, etc.,	Specify: Whi	
6	5-0036	72 hours natural',		15. Decedent's Education	16a. Deced	ent's Usual Occupation	168	b. Kind of Business/In	ndustry
3	21	thin 7;	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done during most of work DO NOT use retired)			
	121	filed w Hygien other th		12 17. Father's Name (First, Middle, Last)	Steam	Fitter 18. Mother's Name	e (First, Middle, Mai	lumbing &	Heating
	lanc	ed ala	To Be	Robert (NMN) Caldwell			MN) Bell	,	
9	Maryland	d 2 should th and Mer 7 la marke traumatic		19a. Informant's Name/Relationship (Type, Print) Nell Caldwell/Wife	1	g Address (Street and Number or Rum		-	
0		Heal		20a Method of Disposition 20b.	Place of Dispo:	Greenbriar Court,		., MD 2104	
0/88	пог	es of T		h⊞Burial 2 ☐ Cremation 3 ☐ Bemoval from State	cemetery, cren	em. Gardens 4-3-		el Air, MI	
-	Baltimore,	permit. Pag Department Important: I eny injury o		21. Signature Funeral Service Licensee	22	Name and Address of Facility	D 7		
$\omega$	11	20 E 2 9		23a. Part 1. Enter the disease, or complications that saused the dear shock, or heart failure. List only one cause of each line.	th Do sot only	317 Cokesbury Roa	d, Abingd	on, MD 210	)09 Approximate
		Dhuaisian		minimodiate Cadse (i iliai	0 64			100	Interval Between Onset and Death
	7	Physician /Medical		disease or condition resulting in death)  Due to (or as a conse	quence of):	on foreign	0, 4/5	9	
		Examiner	L	Sequentially list conditions,	5381	se dem	ensis	1	
_ /	. /	neit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	quence or):				
3	O,	execu an and rial-tra	Exal	that initiated events c. Due to (or as a conservation of the conservation).	quence of):				
61901	68760,	ficate be executed g physician and as the burial-transit	edical	d					
19	ox 6		/Me	IF FEMALE: 23c. If yes, outcome of pregrant				23d. Date of deliv	erv
Q	<u> </u>	law requires that the death certi as been signed by the attending t 2 should be detached for use a	lclan/M	nt the past 12 months?  1 ☐ Yes 2 ☐ No  1 ☐ Uknown		Ectopic pregnancy Other (specify)		Month	Day Year
Ø	P.0	es that the deigned by the be detached	Physi	9 Unknown  Part II. Other significant conditions contributing to death but not re	gulting in the u	adarheing gauss gwan in Bart I	23a Did tohan	cco use contribute to t	the cause of death?
Jarrell # 000	ds,	uires tha signed Id be del	ρ	Part II. Other significant community community to death but not re	saiting in the th	idenying cause given in Farts.	1 ☐ Yes	2 No 3 □ Prol	
E	Vital Records,	law requii as been s 2 should	Completed				24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
Y	II Re	uician: The lav certificate has rector, page 2	Com				autopsy performe 1 Yes 2	death?	2XNo
Da	Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?		Othor	h Check only ne)		
	ō	g Phys er this eral dii	n: To	27. Manner of eath 28a. Date of Injury	28b. Time of	4 Nuising Ac	ome 5 ☐ Residence 28d. Describe how	injury occurred	fy)
E	ion	Attending F r death. ector: After by the funer	atlo	Accident investigation	Injury	M 1 Yes 2 No			
2h	Division	for Attendiater death.  Director: #	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At I building, etc. (Special Coulding)	nome, farm, str ify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Run State)	al Route Number,
Caldwell		spital hours a meral y filled		29a. Certifier Certifying Physician: To the best of my kn					
0		To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	fedical	(Check only 2 Medical Examiner: On the basis of examiner one) and manner stated.	ation and/or in				
		To To	Σ	29b. Signature and tiple of certifier	111	29c. License number	JU1 29d.	Date signed (Month,	Day, Year)
		141		30. Name and address of person who come to cause of death (Ite	m 23a) (Type,	Print)	014	2/ 67/6	0
		11		Irina Mikityanskaya E	500 ly	operthesapeake	Dr. Bel	AIRMO	21014
		Sta Regist	ate rar	31. Date filed (Month, Day, Year) / 32. pegiskrar's Sign	nature Ac	arle		,	1
		TO THE WAY IN THE		The state of the s	4 8	5 (3000)			

DHMH 17 Rev 1/2001

			. For	State of M		d / Depa	artmen	t of He	ealth a		•		n 6	10297
			1 - State Registrar			Cei	tificat	e of E	Death			Reg. No.	0 0	1060
	Physicia	an	Decedent's Name (First, Middle, Last,								<ol><li>Date of De. Month</li></ol>	Day	Year	3. Time of Death
* A.	/Medic		Anne S. Cardina								\pril 1	, 200		8:42 P M
	Examin	er	4a. Facility Name (If not institution, give						Location o	f Death			unty of Deat	
, d		* 5	Upper Chesapeake  5. Social Security Number 6. Secu			ast birthday)		Air	If Under 2	24 Hrs.	8. Date of Birt	th	arforc	
2	Funeral Director			_M 2⊠F	78	Yrs.	Months	Days	Hours	Min.	(Month, Da	у, <sup>Уеа</sup> г) I <b>1, 1</b> 9		hplace (State or Foreign buntry) Bryland
	land ow		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	Mary I sh	tor	MD Baltimore	2	Kir	ngsvill	e							1 ☐ Yes 2XX No
	h the	Director	10e. Street and Number			. <b>.</b>	10f. Zip	Code				10g. Citizen	of What Co	puntry?
	238 c		6615 Mount Vista	Road			2	1087				USA		
	tems	Funeral	11. Walter States	<ol><li>Was Decedent Armed Forces?</li></ol>	?	S. 13.	Was Dece f Yes, spe	dent of His cify Cubar	spanic Orig n, Mexican	gin? (Spec , Puerto R	cify Yes or No lican, etc.)	- 14.	Race - Ame Black, White	nican Indian, e, etc.
36	s afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No		1 🗌 Yes	2 <b>⋈</b> №	Specify:			Sp	ecify:	Jhite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland at Hygiene. A the Hygiene of the than "natural" or items 23a or 28a-f show do ther than "natural" or items 23a or 28a-f show event, I'm Medical Examinar must be notified at	edt	15. Decedent's Edu			16a. Deced	dent's Usu	al Occupa	tion			16b. Kind	of Business/	Industry
212	nin 72	piet	(Specify only highest grad	le completed) College (1-4or	5+1	(Give	kind of wo DO NOT u	rk done di se retired)	uring most	of workin	g			•
21	filed with Hygiene other the ent, the	Completed	12			5	choo.	lteac	her				Edu	cation
ng	al Hygid d other	Be (	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden Sui	mame)	
<u> </u>	2 should be filed volume and Mental Hygie Is marked other traumatic event, In	Jo	Roman Swiders			1			Alexs			jro		
<u>a</u>	permit Pages 1 and 2 should be Department of Health and Menta Importent: If Item 27 is marked any injury or other traumatic evone.		19a. Informant's Name/Relationship (T)					,			Route Number			
a) a)	1 and 1ealth em 27 thar t		Pasquale Cardinale 20a. Method of Disposition	e/husband		lace of Dispo			ita Ko		Kingsv			and 21087 Town, State
פֿר	nt of H		1 Burial 2 ☐ Cremation 3 ☐ F		C	emetery, crer	natory or o	ther place						
Baltimore,	iit. Partmen artment ortent njury		4 ☐ Dogation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		St.	Stani			s of Facility		/2006		imore	
B	Depe Impo		11 301	tephen D.	Coet					NUC	on, Ma			Home, Inc.
	-		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o										1 212	Approximate
	Physician		Immediate Cause (Final	ne cause on each I	ine.	- 50	0	,						Interval Between Onset and Death
) 	/Medical		disease or condition resulting in death)	a Due to (or as	a consequence	uence of):	NOTES							
	Examiner		One and the first area of the second	2	ton	2 5	Sunto	rem	in					10 days
	7 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of).	-							0
V	ocuted and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	me	depo	-							
760,	ite be executed ysician and he burial-transit		1650thing in death) Last	Due to (or as	a consequ	uence o :								
687	physic the t	dical		d	-									
9 X	leath certificete attending phy: I for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	incy						23d	. Date of del	+
Вох	atten atten I for u	cian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3□	Ectopic p Other (s					200	Month	Day Year
o.	the d y the ached	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown										
o.	The law requires that the death certifices sie has been signed by the attending phy page 2 should be detached for use as the	by Pi	Part II. Other significant conditions co	ntributing to death I	but,not res	ulting in the u	nderlying o	ause give	n in Part I.		23e. Did t	obacco use	contribute to	the cause of death?
g	quire an sig uld b	ed b	Enotelange 12	enal 1	سهدد	ب					10	Yes 2 N	lo 3□Pr	obably 4 Honknown
ပ္က	awre	Completed	Alrial Film	ellention	_						24a. Was		4b. Were au	utopsy findings available completion of cause of
Ä	The I	E O	Di-0.2. 1	1.00 t.							perfo	rmed?	death?	2 No
ita	strifted ctor,	Bec	25. Was case referred to medical examiner?		/				26. Place	of Death	(Check only o	ne)		
× ×	hysic his co	2	1 Yes 2 No	Hospital: 1 Hopati		ER/Outpatier		1	4 🗆 140		ne 5∏ Resi			cify)
ב	ing P	on:	27. Manner of Death 1 ☐ Hatural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury		28c. Injury Work			8d. Describe	how injury o	ccurred	
<u>s</u>	tend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	CO. Diago of la	i At he		M		/es 2 □ I		9f Location /	Street and A	lumber or O	ural Cauta Number
Division of Vital Records,	or Al after c Direc in by	Certification:	4 Homicide determined	28e. Place of In building, e	tc. (Specif	y)	eet, tactor	y, office			City or To	wn, State)	iumber or A	ural Route Number,
	To the Hospitel or Attending Physician: The law within 24 burus after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Phy	sician: To the best	of my kno	wledge, deat	h occurred	at the tim	e, date an	d place, a	nd due to the	cause(s) an	d manner as	s stated.
	ne Ho n 24 } ne Fu	Medical	(Check only 2 Medical Exami	iner: On the basis of and manner s	of examina	tion and/or in	vestigation	ı, in my op	inion, dea	th occurre	d at the time,	date and pla	ace, and due	to the cause(s)
	To the within To the comp	ž	29b. Signature and fittle of certifier	1/2		4.	29	c. License	number					h, Day, Year)
)			Marcha A	Krohn	A CONTRACTOR OF THE PARTY OF TH	MI)		1750	0041	0_		04	-02-	2006
	10		30. Name and address of person who co	ompleted cause of	death (Iten	1 23-е (Турв,	Print) /	~	0 -	1.01	2			
	W		31. Date filed (Month, Day, Year)	Call We	rar's Signa	Enloyer	) soce	111	D 2	104	C			
	Sta Registr		APR 0 4 20(		Jan Jigila	e La	COLD B							

4/1/06 2043 PM

Cardinale, Annie #800453687

			For 1 - State Registrar	State of Mary	yland / Dep		lealth and	Mental Hy	711111	10298
			Registrar     Decedent's Name (First, Middle, L.	actl		Timeate of I	Journ	2. Date of De	Reg. No.	3. Time of Death
	Physici		Bould h	Caldwell				Month	Day Yea	r - 200
	/Medic		4a. Facility Name (If not institution, gr		~	4b. City, Town, or	Location of Dea		4c. County of De	
	Examin	Ei	Homewood CENTER	Good Belain	Rd	BALLIMUN	4		N/a	
	Funeral		Social Security Number     6.	Sex 7. Age (II	n yrs. last birthday	If Under 1 Year	If Under 24 Hrs			tirthplace (State or Foreign Country)
п	Director		545 34 5807	1 □ M 2 Ø F 9	2 Yrs.	Months Days	Hours Min	CC to be	24,1913	N.C.
	D .		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or L					10d. Inside City Limits
	aryla shov	_	Toa. State Tob. County	6.	_					1. Pres 2 □ No
	Ba-f	ctc	M.D N	a	3A 141mi				40 000 - (140 -	
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28a-f show the Modeal Examiner must be modified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country
	s 23	eral	3.3.33 AHO. Rd	12. Was Decedent Eve	rin IIS 13	Was Decedent of H	lienanie Origin? (9	Specify Ves or No	(1.5.12	nerican Indian,
	Iter d	i.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces?	- 10	. Was Decedent of H If Yes, specify Cuba	an, Mexican, Pue	rto Rican, etc.)	Black, Wi	
99	urs af	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	<ul><li>Specify:</li></ul>		Specify:	Black
21215-0036	2 hor	Completed	15. Decedent's I	Education	16a. Dec	edent's Usual Dccup	ation	- deine	16b. Kind of Busines	
25	hin 7	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done DO NOT use retired	during most or wo	irking	0	
2	e filed within al Hygiene. I other then " vent, the Ma	00	/2	6		TEacher			DATHINGTE C	City Schools
멀	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle	, Maiden Sumame)	,
<u>ya</u>	Ment Ment arke etic	ဥ	COTONEL HALL					LNOW		
Maryland	2 sho and le m		19a. Informant's Name/Relationship	1.					er, City or Town, State	
	and lealth m 27 her ti		HANJUNIA HARRIY		5312	Bedfield A	LE LOS	VEJas		NS 6
016	Pages 1 and 2 should be filed within 72 hours after death with the Marylan tent of Heatth and Mental Hygiene. Int: If item 27 le marked other then "neturel", or Items 23e or 28a-1 show int: If item 27 le marked other then "heterel", or other treumetic event. The Madical Examiner must be notified a size of the madical Examiner must be notified a		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State	cemetery, cri	ematory or other plac	ce)		20c. Location - City	
Baltimore,	permit. Pages Department of Important: If it any injury or o		`4 □Donation 5 □ Other (Spec		CATTISON	FOREST CEM	eten! 4-	7-06	Bartimone serol Home	MO
39	permit Depar Impor any in		21. Signature of Funeral Service Lice	ensee						
	40 2 8 Q		23a, Part 1. Enter the disease, or co	Sich					nong MD ZI	Z/3 Approximate
	Physician /Medical Examiner		shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	y one cause on each line.  a.  Due to (or as a c	lstage	Deni		o rospilatory c		Interval Between Onset and Death
0,	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. First Interpretate Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co						
P.O. Box 68760	The law requires that the death certificate be the bas been signed by the attending physicionage 2 should be detached for use as the binage.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12[months? 1 □ Yes 21 No. 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tim	Fetal death 3	□Ectopic pregnancy	′		23d. Date of o	delivery Day Year
	w requires that been signed should be dei	by	Part II. Other significant conditions	contributing to death but n	not resulting in the	underlying cause giv	en in Part I.			Probably 4 nknown
I Records,		Completed						24a. Was auto perf 1 ☐ Yes	s an 24b. Were prior to death 2 No 1 1 Y	
Vital	icien: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	l ( it al.		011	100	ath (Check only	one)	-
of \	Phyelcien: this certific al director.	ို	1 Yes 2 No		2 ER/Outpati	ent 3 DOA			idence 6 Other (S	pecify)
	ng fter iner	atlon:	27. Manner of D ath   Natural 5 Pending investigat	28a. Date of Injury (Month, Day Y	'ea <i>r</i> ) 28b. Time Injury	Wo	yat rk? Yes 2 ∐No	28d. Describe	how injury occurred	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home, farm, s (Specify)	street, factory, office		28f. Location City or To	(Street and Number or wn, State)	Rural Route Number,
	e Hospii 24 hour e Funer letely fills	edical		Physician: To the best of naminer: On the basis of examiner stated	camination and/or					
	To the within 2. To the complet	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mo	onth, Day, Year)
)	, , , , , ,		1/ Marks	<del></del>		0 000	5947	3	Merch ?	1 2006
			30. Name and address of person wh	o completed cause of deat	th (Item 23a) (Type	e, Print)	77.10	<u> </u>	Merch 3	1
	<u> </u>		Nolad Pento			n BIND PO	B#303 .	1 Sultimer	e un 21:	239
ľ	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  APR 0 4 200	22. Registrar's		de la			,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 7:50 AM M 3, 2006 April Carolyn Betty Dubin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/26/1929 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 SF 76 MD) Yrs. 212-28-8805 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a State 10h County other than "netural", or Items 23s or 28s-f show rent, the Madical Examiner must be notified at 1 Yes 2 No MD Baltimore Owings Mills Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21117 10 Englefield Square Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimbre, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Real Estate Elementary/Secondary (0-12) Coltege (1-4or 5+) Realtor 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth ery injury or other traumatic event <u>once.</u> Be Conn Margaret Unknown ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Englefield Square Owings Mills, MD 21117 Brian Dubin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Apr 4 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland Killer Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. tmmediate Cause (Final Chronic obstructive **Physician** pulmonary disease or condition resulting in death) YEARS /Medical Due to (or as a consequence of): Examiner S-quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ፩ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 □ No 3 Probably 4 Unknown been si 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (Specify) NO) Pile Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 3 No Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 5 Pending investigation Natural 1 Yes 2 No death. ours after death. neral Director: A filled in by the fu 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) P. 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 3 2006 058303 arlun BALTIMENE UD ZIZOZI 6601 CHARKES, MO Atron 31. Date filed (Month, Day, Year) 32: Registrar's Signature State APR 0 4 2006 Registrar

3,2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 30 Day 2006 Year **Physician** 7:08 AM M Claudine T. Driver /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5 N. Hawthorne Road Middle River Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign VA
 Country) **Funeral** 1 M 2 F Months 1071871942 217-40-8982 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. Count 10d. fnside City Limits **ehow** item 27 is marked other than "natural", or items 23a or 28a-1 sho other traumatic event, the Madical Examinar must be notified at MD 1 Yes 2 No Baltimore Middle River Direct 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 5 N. Hawthorne Road 21220 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: Black 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Child Care other than " Elementary/Secondary (0-12) Colfege (1-4or 5+) Day Care Provider permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Adams Susie Mayo 19a. Informant's Name/Relationship (Type, Print)
Ms. Renee Driver/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 N. Hawthorne Road Middle River, MD 21220 Baltimore, Apr 1 2006 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licenses <sup>2</sup>Cremation and a funeral Alternatives 18900M 8717 Green Pastures Drive Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Physician metastat omonths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part fl. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes certificete has been si rector, page 2 should i Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ▼ No 2 No 1 Yes 2 No Hospitel or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 C-crtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) elp road 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2006 Registrar

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			1 - For State Registrar	State	of Maryla		rtment of tificate o		and Me	ntal Hygie	ene 0 0	6	10301
	- 3		1. Decedent's Name (First, Middle,	Last)					2	Date of Death	Day	Year	3. Time of Death
П	Physici /Medic		Charles D. Ent	_						Month 3	,	<b>G</b>	0535 A M
	Examin		4a. Facility Name (If not institution,		umber)		4b. City, Town	, or Location of	of Death		4c. County of	Death	1
			Coastal Haspice	Atthe	hake		Salist				Wicor	w , (	:0
	Funeral Director		5. Social Security Number 213–24–2594	.Sex 1⊠XM 2□F	7. Age (In yr.	s. last birthday). Yrs.	If Under 1 Yes Months Day		24 Hrs. 8 Min.	Date of Birth (Month, Day, Y	ear)	Cou	place (State or Foreign Intry) Yland
	D .		Usual Residence of Decedent  10a. State 10b. County		100.0	City, Town or Lo	nation		-				10d. Inside City Limits
	ehov	'n	Maryland Somer	set	100.	•	Quarte	er				İ	1 ☐ Yes 2 No
	the M	ect	10e. Street and Number				10f. Zip Code			100	g. Citizen of Wh		
	23a or	Funeral Director	24454 Hideaway I	ane			218			100	U.S.A		and y:
036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iteme 23e or 28a-f ehow any injury or other treumatic event, the Medical Evanities must be notified at once.	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed F	2 Mo ive	i	Vas Decedent of Yes, specify C □ Yes 2🖾 N		gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)		White	ican Indian, , etc. nite
Maryland 21215-0036	vithin 72 ho ne. hen "natur e Medicel	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed	) (1-4or 5+)	(Give	ent's Usual Occ kind of work do OO NOT use ret	ne durina most	t of working	16	Sb. Kind of Busi		
N T	iled v Hygie Iher t	ပိ	7. Father's Name (First, Middle, La	est)		Work	er	18 Mothe	r's Name (	First, Middle, Ma	Constru		ion
/and	uld be f fental h rked ol	To Be	Joseph Ent	131)					bby K		ilden Samame,		
ary	and N		19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailin	g Address (Stre	et and Numbe	or Or Rural I	Route Number, (	City or Town, S.	tate, Zi	ip Code)
	and 2 salth n 27 i		Betty E. Ford (D	aughter)	and the second		Q-10 6-10 - 10 - 10 - 10 - 10 - 10 - 10 -	Kaywood		e – Sali	sbury,	MD	21804
ore	of He		20a. Method of Disposition 1   Burial 2 □ Cremation 3	Bemoval from		Place of Dispo- cemetery, cren	sition (Name of natory or other p	place)	Dat	te 20	c. Location - C	ity or T	own, State
Ē	Pag tment tent: jury c		4 □Donation 5 □Other (Spe	ocify)		White C			4/2/0		ames Qu	art	er, MD
Baltimore,	permit Depar impor any in		21. Signature of Function Service Li Robert H. Bra	dshaw	r.	30	)6 W. Ma	in Str	eet –	ral Home Crisfie	eld, MD	21	1817
			23a. Part1. Enter the disease, or conshock, or heart failure. List of	ny one cause on	each line.						t,		Approximate Interval Between Onset and Death
ī	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		CEBRO (or as a conse	VAS Cu	LAR	Acc	IDE.	NT		-	2 why
	Examiner		Sequentially list conditions,	b								_	
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	) (or as a conse	эциопса оГ).							
,8260,	ficate be executed physicien and s the burial-transit		resulting in death) Last	CDue to	(or as a conse	equence of):							
687	ficate physis the	edical		d.									
P.O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use es	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of preg birth 2 Fe gnant at time of nown	ital death 3	Ectopic pregna Other (specify)				23d. Date Mont		very Day Year
	quires that n signed b uld be deta	b	Part II. Other significant condition	s contributing to	death but not re	esulting in the ur	derlying cause	given in Part I.		1 1			the cause of death?
Division of Vital Records,		Completed								24a. Was an autopsy performe	pri de	or to co ath?	opsy findings available ompletion of cause of
/ita	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	11						Check only one)			
<u>}</u>	Physician: r this certificated director,	ပ	1 ☐ Yes 20 No	Hospital: 1		ER/Outpatien	3 DOA	Other: 4 Nu		5 Residen			ify)
UC C	tending Physician: loeth. tor: Atter this certific the funeral director,	ion:	27. Manner of Death  1 Natural 5 Pending		of Injury nth, Day Year)	28b. Time of Injury	28c. Ir V	njuryat Vork? □Yes 2□I		d. Describe how	injury occurred	1	
S		licat	2 Accident investiga 3 Suicide 6 Could no	t be and Die-	e of Injury - At	home, farm, stre				f. Location (Stre	et and Number	or Rui	ral Route Number,
≥	rs after el Dire ed in b	Certification;	4 Homicide determin		ding, etc. (Spe		on, ruotory, onne			City or Town,	State)		
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier Check only one) Certifying 2 Medical Ex	Physician: To the caminer: On the and man	ne best of my k basis of exami nner stated.	nowledge, death nation and/or inv	occurred at the restigation, in m	time, date and y opinion, deal	d place, an th occurred	d due to the cau at the time, date	se(s) and mani e and place, an	ner as s id due f	stated, to the cause(s)
	To the To the comp	ž	29b. Signature and title of certifier					ense number		290	. Date signed		
,			18Cm	1	~~~	^	1	0584	10		3-3	0 -	06
	10		30. Name and address of person w	1	use of death (It			CT.	SAL	15BUB	RY U	10	21801
	Sta Registr		31. Date filed (Month, Day, Year)		Negistrar's Sig		ed)		.,.				
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Registrar

2006

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				te of Maryland / I				-	•	
		•	_ State	le of Maryland / i		tificate of			2000	10303
			Registrar  1. Decedent's Name (First, Middle, Last)			imouto of	Doutin	2. Date of Death	g. No. U U U	3. Time of Death
	Physicia		Margaret J. Feurer					Month March 2	8, 2006	2:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give street a	nd number)		4b. City, Town, o	r Location of Deat		4c. County of Death	
н			St. Martin's Home			Ca	tonsvill	e	Ba1t	imore
Ì.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		year) 9. Birth	place (State or Foreign intry)
	Director		212-09-9357 1□ M 2 Usual Residence of Decedent	92	Yrs.			Aug. 31,	1913   Mar	yland
	and wo		10a. State 10b. County	10c. City, Tow	m or Lo	cation				10d. Inside City Limits
	Mary a-1 sh	to	MD Baltimore	2		Caton	sville			1 ☐ Yes Ž∏ No
	or 28g	lrec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?
	23a	by Funeral Director	601 Maiden Choice La			_1	.228		United St	
	er des	nue	Am	s Decedent Ever in U.S. ned Forces?	13.	Was Decedent of F f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
36	irs aft	by F	If Y	] Yes 2 [XNo es, Give ar or Dates:		1□Yes 2XNo	Specify:		Specify: Wh	ite
ğ	filed within 72 hours after death with the Maryland Hygiene. vthar than "natural", or Items 23a or 28a-1 show snt, the Medical Examinat must be mutified ut		15. Decedent's Education (Specify only highest grade comp	(otod)	. Dece	dent's Usual Occup	pation	dring 1	6b. Kind of Business/I	ndustry
218	thin 7	Completed	Elementary/Secondary (0-12) Col	lege (1-4or 5+)	life.	DO NOT use retire	d)	iking		
2	led wi	Cor	8		I	Homemaker		- Circl Middle M	Own Ho	me
and	lbe fi	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, M.		
٦	should od Me mark matic	은	August Kelch  19a. Informant's Name/Relationship (Type, Pri	nt) 19t	o. Mailir	na Address (Street		1mina Rau u <i>ral R</i> oute Number,	L LΠ City or Town, State, Zi	ip Code)
<u>S</u>	nd 2 s ulth ar 27 ls r trau		Shirley Sachs Daugh			•		kesville,		
re,	is 1 and 1 december 1	ı	20a. Method of Disposition	20b. Place of		sition (Name of natory or other pla			0c. Location - City or T	own, State
Ē	Page nent c	1	Donation 5 ☐ Other (Specify)	i irom piate		ck Cemete	1	1-2006 B	altimore,	MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic avent, the Medical Exprint of must be multified at once.	1	21. Sometime of Funeral Service	11/1/28	1 22	. Name and Addre	ss of Facility Am	brose Fun	eral Home,	Inc.
	205 20	1	Can um land	ry versy	11.	328 Sulph	ur Sprin	g Rd., Ar	butus, MD	
P			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the death. Do	not ent	er the mode of dyll	ng, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ADVANCE	D	DEME	NTIA	OF ALZ	ZHEIMERS	SEVERAL YEAR
	Examiner			due to (or as a consequence	or):			TY	pt 3	SEVENIC ICHE
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as a consequence	of):					
/	te be executed /sician and e burial-transit	Examiner	that initiated events c.							
760,	oe exe		resulting in death) Last	due to (or as a consequence	of):					
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Box	death certifica e attending phi ed for use as th	Physiclan/Med	in the past 12 months?	Live birth 2 Fetel death Pregnant at time of death		Ectopic pregnanc Other (specify) _	/		Month	Day Year
P.O.	that the de ed by the detached	hys	9 □ Unknown	Unknown			1 % 40	AND DICE		
	Se un e	by F	Part II. Other significant conditions contribution							
ord	w require been si	ted		AMONIA,			,		s 2 □No 3 □ Pro	Dably 4 MONKHOWN
Sec.	has b	Completed by	DISEASE, CHRI	INIC ATR	1A	L FI	BRILLAT	10034a. Was an autopsy perform	24b. Were aut prior to co ed? death?	opsy findings available ompletion of cause of
a	(0 ===			ERTENSION	C	HRONIC		15cm Yes 2	XNo 1 ☐ Yes	2□ No
V.	Physician: r this certificatal director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospita	l: 1  Inpatient 2 ER/O	utnation	t 30 DOA Ott		ath (Check only one	nce 6 Other (Speci	if <sub>V</sub> )
0	tending Physician: leath. tor: After this certific the funeral director,	n: To	27. Manner of Death 28a	Date of Injury 28b.	Time o	28c. Inju	y at	28d. Describe how		477
ion	ttending death. ctor: Aft y the fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(World, Day 16ar)	Injury	M 1	Yes 2 □ No			
Division of Vital Records,	l or Attencafter death Diractor:	Certification:	3 Suicide 6 Could not be determined 28e	Place of Injury - At home, for building, etc. (Specity)	arm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Rui State)	al Route Number,
Q	Hospital or Attending 44 hours after death. Funeral Diractor: After tely filled in by the fune							<u>                                     </u>		
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	Medical	(Check only 2 Medical Examiner: O	To the best of my knowledg the basis of examination and manner stated.						
	within To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month	, Day, Year)
			* Kanallere	any no		D	18362		3-29-2	-006.
	5		30. Name and address of person who complete KOMALK - Danc M.D.	d cause of death (Item 23a) 3 455, Wilk Registrar's Signature	(Type,	Print) AVR. Su	ite 108.	Balto	Md 2 /2:	29.
	Sta	ite_	31. Date filed (Month, Day, Year)	. Registrar's Signature	SLOPA	Mil.			<u> </u>	
	Registi	rar	APR 0 4 2006	The star of the s	A STATE OF THE PARTY OF THE PAR	100				

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DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar

APR 0

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4a, per/II), (854, 4/3/16 II) State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 23, 2006 Georgianna Ford 2:55 Α 4a. Facility Name (If not institution, give street and number)

Joseph Richey Hospice

Anatomy Board of Maryland 4c. County of Death 4b. City. Town, or Location of Death Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🕅 F 251-66-8648 Yrs. SC 66 16, Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 □ No Hartford Bellcamp 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21017 USA 4331 Hamptonhall Court 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 157 Never Married 2 ☐ Married 1 ☐ Yes 2 ♣ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plantation Housekeeper 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Henry Ford Geneva Rutledge 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Futch - Daughter 4331 Hamptonhall Court, Bellcamp, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/30/06 4 Donation 5 Other (Specify) Bethel Cemetery Georgetown, SC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wilds Funeral Home, 130 Merriman Rd., Georgetown, SC ennis Imerica 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) JUNINOMI Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown 2.b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 20 1 ☐ Yes medical 25. Was case referred 26. Place of Death Check only one examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 DOther (Specific 2 No 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month). Day, Year)

Examiner Examine physicien and the burial-transit The law requires that the death certificate be executed 68760 use as the attending detached for P.O. page 2 should be de ປ້ ແດງເຂກາ ແ Division of Vital Records, After this certific funeral director, or Attending death. the filled in by Medicai

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

within 72 hours after

Pages 1 and 2 should be fil ment of Health and Mental H ant: If Item 27 is marked ott

or other

Physician /Medical

Maryland 21215-0036

Baltimore,

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Director

Funeral

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Completed

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MD

Physician/Medical ۾ Completed Be Certification: To

within 24 hours a
To the Funerel E
completely filled To the Hospitel

State Registrar

filed (Month, Day 32 Registrar's

and manner stated

6 Could not be determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title

ORIGINAL

😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Paristrar's Signature

2006

			1 - State Registrar	ate of Mary			of He	alth a	ind Mer	ntal Hyg	giene	06	10308
	8 2		Decedent's Name (First, Middle, Last)							Date of Dea	ith	V	3. Time of Death
П	Physici /Medic		Willard L. Groomes						Aı	oril 2	, 2006	Year	920 AM
	Examin		4a. Facility Name (If not institution, give stree			4b. City, To						nty of Death	,
A S		and the second	1110 Woodheights A					more				/A	
150	Funeral Director		5. Social Security Number 6. Sex 1578-03-6044 15X		yrs. last birthda Yrs.	Months I	Days	If Under 2 Hours	Min.	Date of Birth (Month, Day Ct. 11	(Year)	Cou	place (State or Foreign intry) yland
			Usual Residence of Decedent							-U. II	, 1/1/2		
	irylan show	L	Maryland N/A	100	c. City, Town or Balti								10d. Inside City Limits  XX Yes 2 □ No
	8a-f	Director			Daili								
	2 should be filed within 72 hours after death with the Maryland and Menth Hygiene. and Menth Hygiene. Is marked other than "natural; or Items 23s or 28s-f show is marked other than "natural; or Items or 25s or 28s-f show aumatic avent, In a Medical Examination and a continued at a continued	i Dir	10e. Street and Number 1110 Woodheights A	venue		10f. Zip C	1211				10g. Citizen d U	ISA	intry?
	death ms 2	Funeral	11. Marital Status 12. V	Vas Decedent Ever	in U.S. 1	3. Was Deceder	nt of His	panic Orig	gin? (Specify	y Yes or No-		lace - Ameri	
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<u>γ</u>	in 72 "nat	ojete	15. Decedent's Education (Specify only highest grade control	mpleted)	(G.	cedent's Usual ( ive kind of work e. DO NOT use	done du retired)	ring most	of working		16b. Kind of	Dusiness/ii	ndustry
212	yiene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ster an				sher	Const	ructi	on
pu	be filed stal Hyg od othe avent,	Bec	17. Father's Name (First, Middle, Last)				1				Maiden Sum		
Baltimore, Maryland 21215-0036	should beind Ments marked	10	Clarence Groome								Nicho		
Nar			19a. Informant's Name/Relationship ( <i>Type</i> , Informant's Name/Relationship ( <i>Type</i> , Informationship)	,	19b. Ma	ailing Address (S	Street ar	nd Number	r or Rural R	oute Numbe	r, City or Tou	m, State, Zi	aryland
e)	1 and Health em 27		20a. Method of Disposition	Wife	0b. Pface of Dis	sposition (Name rematory or other			Date		20c. Locatio		
no	Pages nent of I ant: ff ite		1 ★Burial 2 ☐ Cremation 3 ☐ Remo	varirom state		ew Memo:			/7/200	06	Elders	burg.	Maryland
≣	permit. Page Department of Important: ff any injury of once.		21. Signature of Funeral Service Licensee	$\sim 1/$						1			-
<u>~</u>	Depa Impo any i		Durm B.	Hens	N	3631 F	alls	Road	d, Ba	ltimor	e, Mar	yland	. 21211
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused the suse on each line.	death. Do not	enter the mode	of dying,	such as o	cardiac or re	espiratory ari	rest,		Approximate Interval Between Onset and Death
7.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	athe	rasi	lero	2li	1					30 yrs
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events c	,									
760,	ite be executed iysician and ne burial-transit		resulting in death) Last	Due to (or as a co	nsequence of):								
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œ	death e atter d for u	iclar	in the past 12 months?	1□Live birth 2□ 4□Pregnant at time		3 □Ectopic preg 5 □ Other (s <i>pec</i>					1	Month	Day Year
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_	The law requires that the death certifica ete has been signed by the attending ph page 2 should be detached for use as th	by F	Part II. Other significant conditions contribu	uting to death but no	t resulting in th	e underlying cau	use giver	in Part I.			iber.		the cause of death?
ord	w requir been si should	eted	201010000	word in	a.	race		•		1 🗆 Y			bably 4 □Unknown
Records,	e law has b	Completed	amal HI	2440	COLOX	11				24a. Was a autop perfor	sy	b. Were aut prior to co death?	opsy findings available ompletion of cause of
Vital	ding Physician: The h. h. After this certificete ha funeral director, page	e Co	25. Was case referred to medicaf	a a u	Cose	toll	Na	NCC	2	1 ☐ Yes	2 00	1 🗆 Yes	2□ No
	/eicia s certi directo	To Be	examiner?  1 Yes 22 No	itaf:	2 ☐ ER/Outoa	tient 3 DOA	Othor				ence 6 🗆 0	Other (Spec	rfv)
٥	Attending Physician: r death. sctor: After this certifice by the funeral director, i	T.U	27. Manner of Death 2	8a. Date of Injury (Month, Day Ye	28b. Time		c. Injury :				ow injury occ		
<u>ö</u>	endin eath. or: Af he fur	atic	1 Natural 5 Pending 2 Accident investigation		, , , ,	, M		es 2 N	No				
Division of	or Attendate death Director:	Certification.	3 Suicide 6 Could not be 4 Homicide determined 2	8e. Place of Injury - building, etc. (S	At home, farm, pecify)	street, factory,	office		28f.	Location (S City or Tow		mber or Rui	ral Route Number,
_	spital hours ineral y filled		29a. Certifier 1 Certifying Physicia	n: To the best of m	y knowledge, de	eath occurred at	t the time	, date and	d place, and	due to the o	ause(s) and	manner as	stated.
	the Ho iin 24 the Fu	ledical	(Check only 2 Medical Examiner:	On the basis of exa and manner stated.	mination and/o	r investigation, in	n my opi	nion, deat	th occurred	at the time, o	ate and plac	e, and due	to the cause(s)
	To the comple	Σ	30. Name and address of person who complete the Complete	W. O.	Mr.	29c. 1	License	number	-91	1	29d. Date sig	ped (Month	Day, Year)
ř	ndi		30 Name and address of access the access	stand cause of death	A 110	O Print'			-44	5/	- 11	/	11 / = = 1
1	17		50 San J H en C	ey MD	1190W	North	en	PK	wy #	10/1	Saltr	hare	Med 21210
16	Sta		31. Dale filed (Month, Day, Year)	32. Registrar's	Signature	boorde	)						
	Registi	rar	APK U 4 ZUU	O A COLLEGE	of the state of								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item # 20b,c, perFH, 0854, 7/7/06 TT Department of Health and Mental Hygiene Reg. No. UUO Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year Month 31, March 2006 12:26 Geipe Frances /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 119 Central Avenue Baltimore Glyndon | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 20, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 反 F Yrs. 80 Director 214**-**20-6183 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or Items 23a or 28a-f show the Medical Exemiter must be notified at 1 ☐ Yes 2 XNo Be Completed by Funeral Director Baltimore **Glyndon** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 119 Central Avenue 21071 Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hygiene.
art: if item 27 itemarked other than "naturel", or Items 23, and it item 27 items 23, and other treumatic event, it a Medical Extenditor intermation. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yr Housewife 0wn Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Maurice С. Sturm Elsie Reid ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 Central Avenue Mr. Joseph P. Geipe, Sr. Husband Glyndon, Maryland 21071 Place of Disposition (Name of cemetery, crematory or other place)
Carrison Forest Veterans
4/6/06 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Owings Mills 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 

Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Reisterstown, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 Physician ease or condition resulting in death) nears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lineage or injury Due to (or as a consequence of): Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Box 68760, 🖔 that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by t Part II. Other significant Anditions pontributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 Yes 2 AN 3 Probably 4 □Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No cate has I 2 No ⊺ Yes Division of Vital the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Sidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner ath 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) Parkton, Md.

State Registrar char

31. Date filed (Month) Day

ersat

32. Restrar's Signature

Ha

Please Type Print in Black Indelible 1811 From All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>29 **Physician** 2006 4:15 p M March Mary Louise Gohn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore Oak Crest Months Days Hours Min. 8. Date of Birth March 291, 1914 5. Social Security 578 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Maine 1 □ M 2 💢 F 030-07<del>-9678</del> 92 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State er then "natural", or items 23e or 28e-1 show the Medical Examiner must be notified at Baltimore Baltimore 1 Yes 2 No Md. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 8830 Walther Blvd., apt 223 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 5+18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leon D. Mincher Dalton Eleanor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
745 McHenry St. Baltimore, Md. 21230 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai 2002: Mr. Jack Gohn/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-31-06 Towson, Md. Hillton Service Co. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASCUID **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its agents. Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last and Box 68760, Due to (or as a consequence of): Completed by Physician/Medical as attending p 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) detached to P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has b autopsy performed 2 9 No 1 Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Division 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0586 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

03/29/06

8500

32. Registrar's Signature

Pauleville MID LIZZY

d1State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death Month March 29, 2006 **Physician** 4a. Facility Name (If not institution, give street and number) Grayson 10:03 A<sup>M</sup> /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 213-13-7899 Days 1 □ M 2 💢 F Months Director Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle ment of Heatth and Mental Hygiene.

Bant: If item 27 is marked other than "natural", or iteme 23a or 28a-1 ehov ury or other traumatic event, the Madical Examinar intuit te invitting at 1 Nes 2 No Baltimore Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
11a. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) aiver 100th ther's Name (First, Middle, Last) Middle, Maiden Sumame, Be grauson 19b. Mailing Add 10008 20b. Place of Discometed, Method of Disposition Burial 2 Cremation 3 ☐Removal from State permit. Page Department of Important: If eny injury or QDCE. 4 □ Donation 5 □ Other (Specify) 21. Signatu e of Fun (ra) Service allistown, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Friysician Multiple /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, learning to animodiato cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien end ned for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1. ✓ Yes 2 □ No 24a. Was an 1 Yes 2□ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1√XYes 2 □ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred After in a motor 1 Natural 5 Pending investigation Driver death. 29/06 8:41 AM 2 Accident 3 Suicide nours after death nere! Director: / filled in by the fi Vellecle collesion 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) USS (147) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide traniva KILTZ within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) welltallan me OCME March 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUMA 111 Penn Street, Baltimore, Maryland 21201 Registrar's Signature 31. Date filed (Month, Day, Year) State Seguer APR 0 4 2006

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

31. Date filed (Month, Day, Year)

32. Registrar's Signature

600 N. WOLFE ST.

**ORIGINAL** 

BLALUCE 658

BALTIMORE MD 21287

CHRISTOPHER SOMMEMDAY



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

			State of Maryland	/ Depa		f Health a	and M	ental Hygie	9000	10313
			Registrar  1. Decedent's Name (First, Middle, Last)	001	incate c	Death		2. Date of Death	. No. U U U	3. Time of Death
	Physici	an	M. Elizabeth Heinmu	11				Month	Day Yea	r
	/Medic		4a. Facility Name (If not institution, give street and number)	ттег		n, or Location	ot Death	April 1	, 2006 4c. County of De	
	Examin	er	433 S. Rolling Road		ľ	atonsvi			, -	altimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday)	It Under 1 Ye	ar If Under	24 Hrs.	8. Date of Birth (Month, Day, )		Birthplace (State or Foreign Country)
	Director		215-10-1703 1 M 2 XF 93	Yrs.	Months Da	ys Hours	Min.		040	laryland
	pu ,		Usual Residence of Decedent							
	anyla •hov	<u> </u>	10a, State 10b. County 10c, City, T	OWII OF LC						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ecto	Maryland Baltimore			sville		140		X .
	a or	ā			10f. Zip Cod			100	. Citizen of What	
	eath na 23	erai	433 S. Rolling Road  11. Marital Status  12. Was Decedent Ever in U.S.	13 1	Mas Decedent	21228	nin? (Sne	cify Ves or No.		SA merican Indian,
	fter d	Funeral Director	Armed Forces?  1 X Never Married 2 Marned 1 Yes 2 X No				n, Puerto I	cify Yes or No- Rican, etc.)	Black, W	
036	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1□Yes 2□X	No Specify:			Specify: W	nite
215-0036	within 72 hours after death with the Maryland ene. then "natural", or llema 23a or 28e-f ehow ha Madical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	6a. Dece	ient's Usual Oc kind of work do	cupation	t of work	16	b. Kind of Busine	
21	thin 7	npie	Elementary/Secondary (0-12) College (1-4or 5+)	life.	DO NOT use re	tired)	I OF WORK			
2	Secretary Institute									
Maryland	be fill H d oth	Be	17. Father's Name (First, Middle, Last)							
<u>Y</u>	ould be Mental Parked o	2	Henry Albert Heinmuller						Pfeiffe	
Mai	12 sho h and 7 ie m								City or Town, State	i, Zip Code)
	1 and 2 Health tem 27 other tra				1d Trai sition (Name oi			Forge, M	D ZIZIZ  Oc. Location - City	or Town State
Baltimore	permit. Pages 1 and Department of Health Important: If item 27 eny Injury or other tr once.		1 Burial 2 □ Cremation 3 □ Removal from State	etery, crer	natory or other	place)		-	ŕ	
Ħ	it. Pa		4 Donation 5 Other (Specify)  21. Signature 1 Funeral Service Licensee		Baltimor eral Hom	e, MD				
Ba	permit. Departr Importa eny Inji		Edward A. Cregorchik			erar nom sville,				
	*		23a, Part1, Enter the disease, or complications that caused the death,	Do not ent						Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	C > /	7)					finterval Between Onset and Death
8	/Medical		disease or condition resulting in death)  Due to (or as a consequent	ce of):						y vs.
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	te be executed ysicien and le burial-transit	Examiner	that initiated events c.	17	<i></i>	_				4
760,	e exe		resulting in death) Last Due to (or as a consequent	ce of):						
876	cate b	dicai	d							
x 68	entific ding p	Me	IF FEMALE: 23c. ff yes, outcome of pregnancy							
Вох	attene for us	lan	in the past 12 months?	ath 3□	Ectopic pregnal Other (specify				23d. Date of d Month	Day Year
o.	The law requires that the death certificate be executed its has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	1 Yes 2 12 No 4 Pregnant at time of death 9 Unknown 9 Unknown	, ,,	Cities (apeciny	/				
<u>α</u>	that ned by deta		Part ff. Other significant conditions contributing to death but not resulting	g in the u	nderlying cause	given in Part I		23e. Did toba	cco use contribute	to the cause of death?
Records,	quires n sign	d by						1 🗆 Yes	2 No 3	Probably 4 Nonknown
00	s been si should	Siete						24a. Was an		autopsy findings available
Re	sician; The lav certificate has irector, page 2	Completed						autopsy performe	od2 death	
Vital		0	25. Was case referred to medical examiner?			26. Place	ot Death	(Check only one)	5110	
<b>†</b>	> 0 0	To B	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER	Outpatier	t 3 DOA	Other: 4 🗆 Nu	irsing Hon	ne 5 Residen	ce 6 Other (S	oecify)
n of	ding Ph h. After thi tuneral		27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28. Date of Injury (Month, Day Year)	b. Time of Injury		njury at Work?	2	8d. Describe how	injury occurred	
Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation			Yes 2				
Division	f or Attendi efter death Director: A I in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of fnjury - At home building, etc. (Specify)	, farm, str	eet, factory, offi	се	2	28t. Location (Stre City or Town,		Rural Route Number,
	pitei ours e erel [	S	29a. Certifier 1 Certifying Physician: To the best of my knowle	daa daati	occurred at th	a tima data sa	d alass a	and due to the seco	(-) (	
	To the Hospitel or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	Medical	(Check only one) and manner stated.	and/or in	estigation, in π	ny opinion, dea	th occurre	ed at the time, date	and place, and d	ue to the cause(s)
	To the Vithin Fo the Somple	Me	29b. Signature and title of certifier	27	29c. Lic	ense number		290	I. Date signed (Mo	nth, Day, Year)
	0		) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (	MB	D	369	42	- A	pril 3,	2006
ń	1		30. Name and address of person who completed cause of death (Item 23)	a) (Typę.	Print)		_	. 1		21228
X	U		13. TURA KHIA, MD, 1000	1, 1	ederis	A Ro		gtars vi (	e, M	1118
120	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signatur		and a					
200	Registr	ar 001	APR 0 4 2006 Mayers 18.	500	BALLE					

	_	= Stata Registrar				Ce	ertificate	e of D	eath		Rag. I	NO UUD	10314
Physicia		1. Decedent's Name (First, M.	liddle, La	st)						2. Date of D Month		Day Yeer	3. Time of Death
/Medica	al	Darry 1 W. 4a. Facility Name (If not instit	Hol	mes Sr	•							2006	0845 A.M
xamine	er	Sinai Hospit		e street and nui	nber)			town, or Li	ocation of Death	1	•	4c. County of Dea	ath
al	-	5. Social Security Number	6. 9	iex	7. Age (In )	yrs. last birthday	_		If Under 24 Hrs.	8. Date of B	irth	n/a 9. Bi	rthplace (State or Foreign ountry)
any injury or other traumatic avant, the Madical Exactinar must be notified at once.		217-70-1479 Usual Residence of Deceden	)	XIM 2□F		48 Yrs.	Months	Days	Hours Min.	(Month, D			ryland
	7	10a. State 10b. Con			10c.	. City, Town or L	ocation						10d. Inside City Limits 1X Yes 2 □ No
	ecto	MD 10e. Street and Number	n/a			Balt	imore	Codo			10= (	Citizen of Miles C	
1	Funeral Director	4242 Bonner	. Do	ad Ant	#1			2121	6		Tog. (	Citizen of What C USA	.ountry :
	era	11. Marital Status	. KU	12. Was Dece	edent Ever i	in U.S. 13.			panic Origin? (Sp Mexican, Puerto	pecify Yes or N	0-	14. Race - Am	
1	by Fur	1 Never Married 2 3 Widowed 4 NDivo		Armed Fo 1 ☐ Yes If Yes, Giv Year or D	2 <b>X</b> □ <b>Y</b> N∘		If Yes, spec		Mexican, Puerto Specify:	Rican, etc.)		Specify: A f	rican- rican- rican
1	ed	15. Dece	dent's E	ducation		16a. Dece	edent's Usua	I Docupation	on		16b.	Kind of Business	
	Completed	(Specify only hi		(1 College (1	-4or 5+)	(Giv	e kind of wor DO NOT us	rk done dur se retired)	ring most of wor	king			st Office
	Son			1	,	Cle	erk						st UIIIce
	a	17. Father's Name (First, Mid							8. Mother's Nam				
	ဍ	Fred J. Hol				10h Mail	line Address		Bessie			Sy or Town, State,	Tie Codel
						1/07/							
	-	Bonita G. Ma 20a. Method of Disposition	yo/	Sister	20	b. Place of Disp	osition (Nan	riga	ıμr.,	_WOODE Date	20c.	ige, VA Location - City o	r Town, State
		1  Burial 2  Cremat 4  Donation 5  Othe				cemetery, cre King Me			4/7	/06	Woo	odlawn,	MD
		21. Signature of Funeral Sec									7H	PA of	Balto. Co.
		Mn			-	92	200 L	iber	ty Rd.	, Rand	lall	Lstown,	MD 21133
		23a. Part1. Enter the disease shock, or heert failure.	e, or com List only	plications that cone cause on e	aused the cach line.	death. Do not er	nter the mod	e of dying,	such as cardiac	or respiratory	arrest,		Approximate Interval Between
1		Immediate Cause (Finat disease or condition resulting in death)	800	a Propox	phene i	intoxicat	ion						Onset and Death
			(	Due to	or as a con	sequence of):							
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		b. Due to	or as a con	sequence of):				-			
1	aminer	cause. Enter Underlying Cause (Disease or injury that initiated events	1	C.									
1	<u>ш</u>	resulting in death) Last		Due to	or as a con	sequence of):							
	dica		•	d									
	by Physician/Medical	IF FEMALE:		23c. If yes, out	come of are	agnancy							P. C. S.
	cian	23b. Was decedent pregnant in the past 12 months?		1☐Live b	irth 2   F	etel death 3	□Ectopic pro					23d. Date of de Month	Day Year
1	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□ Unkno									
1	oy P	Part II. Other significant con	ditions o	ontributing to de	ath but not	resulting in the	underlying ca	ause given	in Part I.	23e. Did	tobacci	o use contribute t	to the cause of death?
1	ed									1 🗆	Yes	2 €No 3 □ P	robably 4 Unknown
	piet									24a. Was	s an	24b. Were a	utopsy findings available completion of cause of
1	Completed									perf res	ormed?	death?	s 2 No
	Be	25. Was case referred to me- examiner?	dical	Monstell				-	6. Place of Dea	th (Check only	one)		
ı	္	1 ☐ Yes 2 ☐ No 27. Manner of Death				ER/Outpatie						6 □Other (Spe	ecify)
	Certification;	1 □Natural 5 □ Pe	nding estigation	+ /-	h, Day Yea	r) 28b. Time (Injury) Fnd 7:3	NA M	8c. Injury a Work? 1 □ Ye	t s 2400/1No	28d. Describe	now in	lury occurred	
	fica	3 ☐ Suicide 6 ☐ Co	uld not b termined	e 28e. Place	of Injury - A	At home, farm, si			- 7tA	unk 28f. Location	(Street	and Number or F	Rural Rou <u>te Number.</u>
	ert	4  Homicide de	terrilined	buildi	ng, etc. <i>(Sp</i> OUSE	ecify)		, 55		Baltimon	e. M	ate) 4242 Bo D	Rural Route Number, Inner Rd
	Medical C	29a. Certifier 1 Cert (Check only 2 Medi	ifying Ph	ysician: To the	best of my asis of exam	knowledge, dea nination and/or i	th occurred anvestigation,	at the time, in my opin	date and place,	and due to the	cause	(s) and manner a and place, and du	is stated. e to the cause(s)
	Mec	29b. Signature and title of cer		and man	ner stated.			. License n				Date signed (Mon	
1		Maria		ho - 41	2.00	M		C.M.				il 02, 2	
	- 1	TALL STATES											

2006

Division of Vital Records, P.O.

JOHN HANSE

Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2006 **Physician** 11:10p M 2 April John F. Hansel /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Stella MAris Hospice Towson Baltimore If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 1, 1941 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Maryland Hours **½**M 2□ F 64 212-40-7327 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show. r than "natural", or itams 23a or 28a-f sho Ita Medical Examinar must be notified at 1 ☐ Yes 2 ☒ No MD Baltimore Essex Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 461 Torner Road 21221 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2€ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Northrop Elementary/Secondary (0-12) College (1-4or 5+) Quality Control Inspector Grumman 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Frances E. Link John H. Hansel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar important: If Item 27 is any injury or other trau once. Connie Hansel / wife 461 Torner Road Baltimore MD 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore MD 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 4/4/06 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 300 MACE Ave. 21. Signature of Funeral Service Licenses Balto. MD ex 21221 Connelly Funeral Home of Essex nn Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician NASAL SQUAMAUS CELL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of). Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an autopsy 1 ☐ Yes 2X No ieral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Hospital or Attanding 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral ( 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 43721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. TARIQ MAHMOOD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend item#20b, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UUS Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 4:300 toril **Physician** FLORENCE ORINA HAWKINS 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** BALTIMO HOSPITA 1 timore INAI 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F 73 218-28-4289 Yrs Director 12/14/1932 MARYLAND Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State 17 Is marked other than "naturel", or Iteme 23a or 28a-f show froumatic event, the Modical Examinar must be notified at MD N/A BALTIMORE CITY 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5431 LYNVIEW AVENUE USA 21215 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes ② Cho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: þ BLACK 3X Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPER DOMESTIC 8TH Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental LEWIS LYLES, SR. MAZIE JOHNSON ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth Item 27 I GLENORA MCLAUGHLIN/SISTER 5431 LYNVIEW AVENUE, BALTIMORE, MD 21215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
MT. CARMEL CEM. 20a Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If Ite eny Injury or of once. XIXBurial 2 Cremation 3 Removal from State BALTIMORE, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, 21. Signature of Foneral Service Licensee Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HERINE ANCER **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intime hate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): attending physicien for use as the buria Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) o 3 ۵. ate hes been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 (Minknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate of Vital Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 P/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No this After thi funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury Division Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the To the Hospitel or Attend within 24 hours after death To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Flarifying Physician: To the best of my knowledge, denth occurred at the time, date and place, and due to the nause(s) and marrier as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified D0054558 MD 2401 W. Belvedere Ave to completed cause of death (Item 23a) (Type, Print) Name and address of person FreDersck Ke, IR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR 0 4 2006 Registrar

Enc.

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		Unpend item#	State of Maryland / D	E, C854, 4/10 epartment of I	Health and M	lental Hyg	iene				
		1 - Stete Registrar		Certificate of	Death	1	ag. No. () () ()	10317			
Physicia	an	Decedent's Name (First, Middle, Last)				2. Date of Deat Month	Day Year	3. Time of Death			
/Medic	al	WANDA  4a. Facility Name (If not institution, give s	HAMILTON	4b. City. Town	or Location of Death	MARCH	30, 2006 4c. County of Death	1214 P "	_		
Examin	er	1005 N. BENTALOU S		BALTIMO			N/A				
Funeral		Social Security Number     6. Sep.	144 005	Months Davs		8. Date of Birth (Month, Day,	9. Birth	place (State or Foreign	7		
Director		212 96 7048 Usual Residence of Decedent	x 40	rs.		SEPT.	9,1965 MI	) <b>.</b>	_		
Mot #		10a. State 10b. County	10c. City, Town			·		10d. Inside City Limits			
liffed Liffed	ctor	MD. N/A	B	BALTIMORE				1 X Yes 2 No			
Department of Health and Mental Hygiene. Important: if items 23a or 23s-f show any injury or other treumatic event, it a Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 1005 N. BENTA	LOU ST.	10f. Zip Code	1216	1	0g. Citizen of What Cou USA	intry?			
ms 23	era		12. Was Decedent Ever in U.S.	13. Was Decedent of	Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer				
or its	/ Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes Give	1 Yes, specify Cut	pan, Mexican, Puerto Specify:	Hican, etc.)	Black, White				
tural', al Exa	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Decedent's Usual Occu		1	16b. Kind of Business/l		_		
n na Aedic	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give kind of work done life. DO NOT use retire	during most of work	ring	EPT. OF	•			
giene.	Com	Elementary/Secondary (0-12) 12TH	College (1-4or 5+) ADM	INISTRAT	IVE ASSI	1	ND REGULA				
d oth	Be	17. Father's Name (First, Middle, Last) EDMOND HAMIL	TON		18. Mother's Name (First, Middle, Ma LOUISE REDFI						
narke marke	2	19a. Informant's Name/Relationship (Ty	pe. Print) 19b.	Mailing Address (Stree	and Number or Rur	ral Route Number	, City or Town, State, Z	ip Code)	_		
atth ar 27 is r treu		LOUISE REDFEARN	CONTRACTOR OF THE	4 444			E. BALTO	2320	Ç		
of Hear item		20a. Method of Disposition  128 Burial 2 Gremation 3 GF	20b. Place of	Disposition (Name of v, crematory or other pla			20c. Location - City or				
ant: fl		4 Donation 5 Other (Specify)	More More	4-1 -6.	m.PK		altimore		0		
Depart Import any inj once.		21. Signature of Funeral Service Licens	90	22. Name and Addr CALVIN	B. SCRU	GGS FUN	ERAL HOMI	3			
0 = 4 0	-	23a, Part 1. Enter the disease, or compl	ications that caused the death. Do n				BALTO, MD	21213 Approximate	-		
ysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or cause in and narcotic (methadone and morphine) intoxication  Interval Between Onset and Death On									
Medical		resulting in death)  Due to (or as a consequence of):									
kaminer		Sequentially list conditions.	)					*			
aslt.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	f):				4.1			
al-trar	Exan	resulting in death) Last  Due to (or as a consequence of):									
physician and the burial-transIt	lical	d									
ing ph	Medi	IF FEMALE:									
attending ph I for use as th	ian/	23b. Was decedent pregnant in the past 12 months?					23d. Date of deli Month	very Day Year			
as been signed by the attending physicis 2 should be detached for use as the bu	Physician/Med	1 ☐ Yes 2 ☐ No 9 X Unknown									
been signed by the should be detached	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute									
en sig ould b		1 Tyes 2 No 3 Probably 4 Unknow									
8 01	Completed					24a. Was a autops	y prior to d	topsy findings available completion of cause of	•		
pa							2□No 1 Yes	2□ No			
this certificate ha al director, page 2	o Be	25. Was case referred to medical examiner? 1∑ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient 3 DOA	ther	th (Check only on		o(4) CODATA	_		
<u>. w</u> - O	H	27. Manner of Death	28a. Date of Injury 28b. T	ime of 28c. Inju	ury at		me 5 Residence 6 Rother (Specify) SCENE 28d. Describe how injury occurred				
within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	atio	1 □Natural 5 □ Pending 2 □ Accident investigation	Fnd 3/30/06 Fnd		Work?		unk				
fter de Sirecto in by ti	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify) HOUSE	rm, street, factory, office	e .	City or Towl	reet and Number or Run, State) 1005 N.	ral Route Number. Bentalou St.	,		
erai C		29a, Certifier 1 Certifying Phy	sician: To the best of my knowledge	death occurred at the	time, date and place	Baltimore		stated			
ne Fun.	edicai		ner: On the basis of examination and manner stated.								
withir To th comp	Me	29b. Signature and title of certifier		29c. Licer	nse number		9d. Date signed (Monti				
		+ande Four	half, nu		OCME		MARCH 31,	2006			
		30. Name and address of person who co	ompleted cause of death (Item 23a) ( WCHNALL, MN 11		EET. BALT	IMORE M	ARYT,AND 21	201			
	1 '	I I WILL WILL WITH	MAINULLING 1	~ ~~10							

State Registrar

tamela E. Southall, mD = 31. Date filed (Month, Day, Year) 32. Paistrar's Signature APR 0 4 2006

Division of Vital Records, P.O. Box 68760,

				State of Man					_	10210
			1 - For State Registrar			tificate of		Reg.	4000	10310
	Physici	an	Decedent's Name (First, Middle, Last)     A			) 1	- 5.4	2. Date of Death Month	Day Yeer	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give s	etmat and number)			r Location of Death	April	2 200 4c. County of Dea	
	Examin	er	Johns Horkins Hose			Baltimo			n/a	
	Funeral		5. Social Security Number 6. Sex	7. Age (li	n yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	9 Bir	thplace (State or Foreign ountry)
	Director		220-21-4823 Usuel Residence of Decedent	M 2 X 1	9 Yrs.	World Days	Tiodio Nani.	Nov. 23		MD .
	land ow		10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Mary B-f sh	tor	MD Baltimo	re	Cockeys	ville				1 ☐ Yes 2 ☐ No
	iff the	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What C	ountry?
	s 23e	Frail	14101 Cuba Rd.	10 Was Basedon Fre		21030		-4-24	USA	ariana (a dia a
	ter de	Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No	r in U.S. 13. 1	f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	14. Race - Ame Black, Whi	
9 9	ours a		3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates:		1 ☐ Yes 2 № No	Specify:		Specify:	white
2	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or ttems 23e or 28e-f show ent. The Mydical Evaintrier must be rudified at	Completed by	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done	during most of working	ng 16b	. Kind of Business	/Industry
12	within ene. then	duc	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	a)		n / n	
9	filled Hygi other	Be Co	17. Father's Name (First, Middle, Last)	n/a	n/a		18. Mother's Name	(First, Middle, Maid	n/a den Sumame)	
<u>Jar</u>	uld be Menta urked utic ev	To B	Thomas Grason H	arris, Jr.			Kym Mic	helle Mac	den	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Erraniner must be recilied at once.		19a. Informant's Name/Relationship (Ty	paren	เเร		and Number or Rura			
e)	1 and Health em 27 ther t	3	Mr. & Mrs. Thoma 20a. Method of Disposition		20b. Place of Dispo	sition (Name of			Ile, MD :	
no	Pages nent of I snt: If its ury or o		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	Removal from State	cemetery, crer Metro Cre	natory or other plac	1		tonsville	
Baltimore,	mit. Poartme		21. Signature of Funeral Service Livens		22	Name and Addre	ss of Facility	723	12 1676	340
m	Depa Impo any i		Bryan W. Clar	y /	1	emmon F 0 W. Pac	uneral Ho donia Rd.	me of Du , Timoniu	ilaney Va im,_MD 2	alley, Inc. 21093
			23a. Part1. Enter the disease, x complishock, or heart failure. List only or	ications that caused the	e death. Do not ent	er the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Enterosa	eter sep	sis				Onset and Death  10 day 5
	/Medical Examiner		resulting in Geatily	Due to (or as a co	onsequence of):					,
		er	if any, leading to immediate	Due to (or as a co	onsequence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or irijury that initiated events	s						_
760,	te be executed ysician and le burial-transit	EX	resulting in death) Last	Due to (or as a co	onsequence of);					
$\infty$		dicai		J						
9 X	certifi nding use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p					23d. Date of de	livery
.O. Box	death e atter	iciai	in the past 12 months?	1☐Live birth 2☐ 4☐Pregnant at tim		Ectopic pregnancy Other (specify)			Month	Day Year
o.	at the i by th stache	Phys	9 Unknown	9□ Unknown						
Division of Vital Records, P.	res th signec	byl	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.  239. Did toba  Renal Part II.  239. Did toba						N /	o the cause of death?
Š	w requir been si should	etec	Renal failure, chronic osteomyelltis, +troine,							
Rec	he law e has ige 2	mpi	sichle cell anemi	2				24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
ta	icien: Th	Be Co	25. Was case referred to medical				26. Place of Death		No 1□Yes	2 □ No
<u> </u>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 No	lospital:	2 ER/Outpatien	it 3□ DOA Oth	05	ne 5 Residence	e 6 □Other (Spe	cify)
0 0	ing Pt	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time of Injury	Wor	k?	28d. Describe how i	njury occurred	
<u>s</u>	ttend death stor: / the f	icati	2 Accident Investigation M 1 Yes 2 No 3 Suicide 6 Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the Could not be considered by the country of the co						tand Number or R	ural Route Number,
<u>&gt;</u>	after Direction by	Certification:	4 Homicide determined	building, etc. (S	Specify)	eet, factory, office		City or Town, S.	tate)	siai i loate rumbel,
	To the Hospitel or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 1 Certifying Physical Examination	sician: To the best of m	ny knowledge, death	occurred at the tir	me, date and place, a	and due to the cause	e(s) and manner a	s stated.
	To the He within 24 To the Fe complete	ledicai	one)	ner: On the basis of ex and manner stated						
	with To	Σ	29b. Signature and title of certifier	)		29c. Licens			Date signed (Mont	
	2001		30. Name and address of person who co	modeled source of de-	h (Item 23a) /Tuan	Print)	0112	40	12,1	2006
	2		Chis tophe Ga water	Pedialic Ke	matelozilo	Celeza.	CMSC 800, 6	500 N. Wolf	est, But	imore, MD 21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	020° B			1	
	Registr	ar	APR 0 4 20	06 100000	for some	All Control				

			For State Registrar	State of Mary		artment of H			2006	10319
			Registrar  1. Decedent's Name (First, Middle, Last	)	Cei	lilicate of t	- Jeani	2. Date of Death	ig. No.U U (. 1	3. Time of Death
	Physicia		Gustav	Edward	Herzer			April 3,	Day Y	1:15 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give		Her Zer	4b. City, Town, or	Location of De		4c. County of	
	Examin	E1	Glen Meadows			Glen	Arm		Balt	imore
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 F	Hrs. 8. Date of Birth (Month, Day,	9	Birthplace (State or Foreign
и	Director		220-14-2007	JM 2□F	89 Yrs.	monais bays	1,00,0	Aug. 10,	1916	Maryland
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation		···-		10d. Inside City Limits
	daryl f sho	ō	Maryland Baltimor	e	G1e	n Arm				1 ☐ Yes 💥 ☐ No
	28a-	rec	10e, Street and Number			10f. Zip Code		10	og. Citizen of Wh	at Country?
	h with	Funeral Director	11630 Glen Arm Ro	ad		2105	7		U.S	.A.
	deat	ner	11. Marital Status	12. Was Decedent Ever	r in U.S. 13.	Was Decedent of Hi	ispanic Origin? In, Mexican, Pu	(Specify Yes or No- uerto Rican, etc.)		American Indian, White, etc.
36	or Its	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify:	
Ö	72 hours after death with the Maryland natural', or Itams 23e or 28a-f show Jigal Eva Tinet must be rollified at	d by	3 Widowed 4 Divorced  15, Decedent's Edu	Year or Dates:		dent's Usual Occupa	ation		16b. Kind of Busin	White
5	in 72 "na" r	Completed	(Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	during most of a	working	OD. Parta of Dasi	no sa mado ny
212	d within piene. r than "	шо	Elementary/Secondary (0-12)	College (1-4or 5+) <b>5</b> +		Professo	r		Loyola (	College
b	al Hyg	Be C	17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle, M	Maiden Sumame)	
/lai	Menta	10	Gustav Herzer	, Jr.			Susar	1 В.	Roddy	
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or Itams 23e or 28e-f show injury or other traumatic avant, the Medical Evantiner must be notified at 9.		19a. Informant's Name/Relationship (T)			•		r Rural Route Number,	•	
	1 and lealth im 27 ihar ti	1 3	Susan E. Thompsor  20a, Method of Disposition			Charles			SON, Mar 20c. Location - Ci	yland 21204
Baltimore,	Pages nent of H int: If its iry or of		1 XBurial 2 ☐ Cremation 3 ☐ F	removal from State	-	esition (Name of matory or other place	1	t de		
Ħ	permit. Page Department Important: Il any injury o	- 1	Donation 5 ☐ Other (Specify,			rk Cemete				ore, Maryland l Home, Inc.
Ba	permi Depa Impo any is	de d	Tank Magan			1050 York		Towson, M		21204
	100		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the	death. Do not ent	er the mode of dyin	g, such as card	diac or respiratory arre	est,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		CEMIT					Onset and Death  24 hours
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):	0-21/20-2	1 211	140 741	AFCTA	E -11000
П		Examiner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co		CHANDED LA	11 LDIC	MI 2nA.	12 11/1/16	A J Duda
7	ted		cause. Enter Underlying Cause (Disease or injury	JUT Pi	TION		Sec. 1.13		GWERKS	
V	be executed ician and burial-transit	xar	that initiated events resulting in death) Last	Due to (or as a co	insequence of):		-a 1		Sec.	
8760,	ate be e hysician the buria		(	DYS	HALL	H DUE	1,0 (			AR 3 months
9	tificate ig phys as the	ledi				<u> </u>		ACCID	EN	
Вох	eath certific attending p	an/h	23b. was decedent pregnant	23c. If yes, outcome of p		∃Ectopic pregnancy	,		23d. Date	,
O. E	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the buriat-transit	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at tim 9☐ Unknown	e of death 5 [	Other (specify)			Width	, Day , our
Ρ.	that the de ed by the detached		Part II. Other significent conditions co	ntributing to death but n	ot resulting in the u	nderiving cause give	en in Part I.	23e. Did tob	acco use contrib	ute to the cause of death?
of Vital Records,	uires thai signed I d be det	d by	DIABET	ES MI		11 2U		1 □ Ye	s 2 No 3	☐ Probably 4 ☐ Unknown
COL	w requir	Completed	DEMEN	STIA				24a. Was ar	24b. We	ere autopsy findings available
Re	The lavate has	dmo	7 11 12					autops:	ged? dea	or to completion of cause of ath? ]Yes 2□ No
tal	- G	0	25. Was case referred to medical				26. Place of	1 ☐ Yes 2 Death (Check only on	7	165 2010
<u> </u>	d is	O B	examiner?	Hospital:	2 ER/Outpatie	nt 3 DOA Oth	Later Action	ng Home 5 Reside		(Specify)
0	ding Ph h. After th funeral	J : UC	27. Manner of Death  1 SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c, Injur Wor	y at k?	28d. Describe ho	w injury occurred	
Siol	Attanding r death. actor: After by the fune	catic	2 Accident investigation				Yes 2 □ No			
Division	or Attandii after death. Diractor: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)	reet, factory, office		28t. Location (Sti City or Town		or Rural Route Number,
	spital ours naral filled		29a. Certifier Certifying Phy	sician: To the best of m	ny knowledge, deat	h occurred at the tir	ne, date and pl	lace, and due to the ca	use(s) and manr	ner as stated.
	To the Hospital or Attanowithin 24 hours after death To the Funaral Diractor:	edical	one)	iner: On the basis of example and manner stated						
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	Can Can	Jon M.	29c. Licens	number 7	28	ou. Date signed (	Month, Day, Year)
7	13		30 Name and address of person who s	ompleted cause of death	(Item 23Å) (Type	Print			7'0	8 2006
	10		2E KOLLING		-100	BACIL	MORE	2 m	1122	8
	Sta		31. Date filed (Month, Day, Year) APR 0 4 200	37. Registrar's	Signature	all 3				
	Registr	ar	ALIN U & ZUU	6 / 60	Jo stagen	W.J.S.				

Physician   Tony Ray   House on St.   A Morth   Pay   Morth   Pay   A Not   12, 25			For State Registrar	State of Maryla		ent of Hea ate of Dea		Reg	ene	6 1032
Social Service Number of Secretary Number of S	/Medic	al	Tony Ray	Honston	1 C 4b. C			A Month s	1 201	
The State   Top County   Top	33274		5. Social Security Number 6. Se 216 28 8663	x 7. Age (In yrs	. last birthday) If Un Mont	der 1 Year   If L	ours Min.	8. Date of Birth (Month, Day, Y JUNE 20,19	(ear)	
Specify only highest product completed)   Specify only highest product completed product produ	the Maryland 28a-f show	rector	10a. State 10b. County  M.D N/C		antimon &	Zip Code		100	. Citizen of Wh	10d. Inside City Limi
Specify orly highest poids completed)   Specify orly highest poids or highest poids completed)   Specify or highest poids or highest poids completed)   Specify or highest poids or highest poids completed)   Specify or highest poids or high poids or hi	ifter death with ir ftems 23a or ult af innet be	Funeral Di	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De	2/2/3 acedent of Hispan specify Cuban, Me			U.S.A. 14. Race - Black,	American Indian,
19   19   19   19   19   19   19   19	n 72	npieted by	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's L (Give kind of life. DO NO	Isual Occupation work done during Tuse retired)	-	ng	Bb. Kind of Busin	ness/Industry
20. Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace of Deposition Name of Control Page 2016 Pace 2016 Page 2016 Pa	be fill	Be	17. Father's Name (First, Middle, Last)		SAND 6 K	18.		(First, Middle, Ma		steel
Physician (Medical Examiner)  Physic	es 1 and 2 shool of Health and filem 27 is m		19a. Informant's Name/Relationship (T)	Zob.	231 E.B	ess (Street and North 1881)  Ideal 18 Street Name of	vumber or Rura	Route Number, C	1213	
Physician (Modical Examinine)  The part of the part failure. List only one cause on each line. Interestable Cause (Final Burkers)  The part of the par	permit. Pag Department important: f any injury o		4 ☐ Donation 5 ☐ Other (Specify,	Gree Gree						
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of or an expectation of the consequence of or an expectation of the consequence of the consequence of the consequence of the co	/Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition	a. Metast	atic Pr					Approximate Interval Between Onset and Death
Section of the control of the cause of death   Check only   Control of completion of control of completion of control of completion of control of completion of control of completion of control of completion of control	and il-transit		that initiated events	Due to (or as a consect.	,					
25. Was case referred to medical examiner?  1   Yes   2   No	the death certificate to the attending physic ched for use as the ball		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 □Ectopi					
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)    27. Manny of Death   1   Veatural   5   Pending investigation   3   Suicide   4   Homicide	v requires that been signed b should be deta		Part II. Other significant conditions co Chronic Obstru	ntribyting to death but not re	sulting in the underbin	`		1 ☐ Yes	2 No 3	Probably 4 Unknow
The property of the control of the c		0	eyaminer?				Place of Death	autopsy performs	d? dea	ath?
building, etc. (Specify)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	ding Phya I. After this funeral dis	<u>٩</u> .	1 Yes 2 No  27. Manny of Death  1 Vatural 5 Pending 2 Accident investigation	1 inpatient 2	28b. Time of Injury	28c. Injury at Work?	2			
Leone C. Wills M. 1D. 191363 April 1, 2006	ospital or Attu hours after de uneral Directo y filled in by ti	ai Certific	4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc. (Spec	owledge, death occur	red at the time, da	ate and place, a	City or Town,	State) se(s) and mann	er as stated.
30. Name and address of person who completed cause of death (tem 23a) (Type, Print) Creorge E. Wills R. M. 3900 Loch Raven Boulevard, Baltimon, MD 2	To the Ho within 24 To the Fu	Medic	one)	and manner stated.	N .	29c. License nun	nber	290	Date signed (	Month, Day, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	8		George E. W	ricks to MU.		ich Rai	ven Bo		1	

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			1 - For State Registrar	State of Maryla			lealth an	-	ene	10000
					Cei	rtificate of l	Death		No.UU	10366
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Yea	
	/Medic		MAGGIE	HARRIS		44 Oct 7-	-1	APRIL	4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give share BOR WOSP			4b. City, Town, or	I MORE	eatn	46. County of De	odin
	Eupaval		HARBOR HOSP  5. Social Security Number  6. Sep		. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birth	9. E	irthplace (State or Foreign
	Funeral Director			M 20 F 8	7 Yrs.	Months Days	Hours N	Hrs. 8. Date of Birth (Month, Day, )	(ear) 1919	Sirthplace (State or Foreign Country)
	_		Usual Residence of Decedent					Juic 11,		
	nylan show	L	10a. State 10b. County	10c. C	ity, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☑ No
	Be-f s	cto	MD		BALTI	MOLE				
	vith th	Funeral Director	10e. Street and Number	01		10f. Zip Code	1 -	109	. Citizen of What	Country?
	s 23e	rai	1901 CHERRY H	ILL Kol.		212	- 1 -	/5	4.5, A,	
	er de Item	nue	11. Marital Status	12. Was Decedent Eyer in t Armed Forces? 1 ☐ Yes 2 ☑ No	J.S.   13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin's an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	Black, W	nerican Indian, nite, etc.
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: D	JAOK
21215-0036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23e or 28e-1 show is Madical Examiter (1811 be motified at	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation	16	Bb. Kind of Busines	ss/Industry
215	hin 7;	ple	(Specify only highest grade	e completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of d)	working		
21	d with	Completed	Combination (6 12)	00/1090 (1-401-51)		LABORE	ER		FOOD	Service
p	be filed within tal Hygiene. d other then event, Ire M	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle, Ma	aiden Sumame)	
yla	Ment Ment arkec	70	STEVE BLACKNE	LL				FARRING		
Maryland	ges 1 and 2 should t of Health and Men if item 27 ie marke or other treumatic		19a. Informant's Name/Relationship (Ty			-		r Rural Route Number		1.
	l and lealth im 27 her ti		CONNIE HARRIS		Place of Disease	25 RAMB	lewool.	Date 20	c. Location - City	1239 ADT D
Por	Pages nent of the sent: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	enioval irom state i		nsition (Name of matory or other place			· ·	4.5
Baltimore,	rt. Partmer rtent rjury		' 4 □ Donation 5 □ Other (Specify)		Elm (	"reMATOR	7 14.	· 3 - 06 13	SAITO., M	1D
Ba	permit. Page Department Importent: Il eny injury o		21. Signature of Funeral Service License	2:00	Į Š	lictest Zi	glier	in Suc P.A. AVE. BAIT	o. Mb. 2	7 7 9
			23a. Part1. Enter the disease, o colopli	ications that caused the dea	th. Do not ent	er the mode of dvin	Derick	diac or respiratory arres	5. 1910. 2	Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.	. ^		·91	,	•	Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)	Due to (or as a conse			00.0			+ Days
	Examiner			Uringry	1 100	act =	Tote	ction		7 days
		Jer.	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a conse	ence of):					1211
}	cuted nd ransif	Examiner	that initiated events	Diabe	tes	Mell	itus			10 Years
Ö,	e exe ian a urial-l		resulting in death) Last	Due to (or as a conse	quence of):					
8760	death certificate be executed e attending physician and id for use as the buriat-transit	dicai		d		<del></del>				
9 X	leath certific attending pl	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregr	ancy				and Data of	dalbura.
Вох	atten for u	ian	in the past 12 months?	1 Live birth 2 ☐ Fet	al déath 3 [	Ectopic pregnancy Other (specify)			23d. Date of o Month	Day Year
o.	the y th iche	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	33411	_ caro, (opcony)				
<u> </u>	law requires that as been signed b 2 should be deta	by Pł	Part II. Other significant conditions con	ntributing to death but not re	sulting in the u	nderlying cause givi	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
ecords,	w requires been signi should be							1 ☐ Yes	2 No 3	Probably 4 Unknown
000	aw requisite should	Completed						24a. Was an	24b. Were	autopsy findings available
$\alpha$	9 2 9	E						— autopsy performe	ed? death	
Vital	yslcian: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?				26. Place of	Death (Check only one)		
of <	Physician: r this certificaral director,	2	1 Yes 2 No		ER/Outpatier	nt 3□DOA Oth	er: 4 🗌 Nursin	ng Home 5 ☐ Residen	ce 6 □Other (S	pecify)
E C	ding P h. After t funera	on:	27. Manner of Death  1. ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Worl	k?	28d. Describe how	injury occurred	
Sio	ten leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	On Division Attained Attained			Yes 2 □ No	296 Leasting (Street	at and Alumbar ar	Dural Cauta Alumbas
Division	in Line	Certification;	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	eet, factory, office		City or Town,		Rural Route Number,
_	Hospitel 4 hours a Funerel I tely filled		29a. Certifier 1 Certifying Phys	sician: To the best of my kn	owledge, death	n occurred at the tin	ne, date and pl	lace, and due to the cau	se(s) and manner	as stated.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examinations)	ner: On the basis of examin and manner stated.	ation and/or in	vestigation, in my o	pinion, death o	occurred at the time, dat	e and place, and d	ue to the cause(s)
	To the Hospitel within 24 hours a To the Funerel Completely filled	Ž	29b. Signature and title of certifier	2.1000	110	29c. License	e number	290	d. Date signed (Mo	
	:0		Mob 7	eyssa 1	VIN	000	OKE	A		02,2006
	3		30. Name and address of person who co		m 23a) (Type,	Print) EY	013	L. FEYS		,
			3001 S HHN 31. Date filed (Month, Day, Year)	JOVER S  32. Registrar's Sign	ature		imore	2 MD	2122	-7
	Sta Registr		APR 0 4 2006	Alexand A	Local	1				
			- L000	8	11					

	1- State of Maryland	Department of Health and M Certificate of Death	lental Hygiene
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year March 30, 2006 3:00 p M
/Medical Examiner	Fred William Inman  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Funeral	Upper Chesapeake Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. last	Bel Air  birthday) If Under 1 Year   If Under 24 Hrs.	Harford  8. Date of Birth  9. Birthplace (State or Foreign
Director	410-22-1341 ¹⅓ <sup>M 2□</sup> F 84	Yrs. Months Days Hours Min.	Sept. 27, 1921 Tennessee
viand ow	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Location	10d. Inside City Limits
e Man	MD Harford F	allston	1 ☐ Yes 2 💢 No
with the Mar a or 28a-f el Les notified Director	3201 Canterbury Lane	10f. Zip Code <b>21 047</b>	10g. Citizen of What Country?
6 Miler death v in Hems 234 Miliet must Funeral	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	
036 urs after alf, or the corrupte	1 ☐ Never Married 2 ☒ Married  1 ☐ Never Married 2 ☒ Married  1 ☒ Yes 2 ☐ Nd ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Yes 2 No Specify:	Black, White, etc.  Specify: White
5-00 72 hour maturum alload is	15. Decedent's Education 1 (Specify only highest grade completed)	6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "insturel", or Items 23s or 28s-f show only injury or other traumatic event, Ite Mudical Exertil or must be rigitlised at once.  To Be Completed by Funeral Director	12 College (1-4015+)	Store Room Clerk	Baltimore Co. Utilitie
yland be fill	17. Father's Name (First, Middle, Last)  Hobert William Inman	18. Mother's Name Kather:	ine Elizabeth Rather
Mary d 2 she th and 7 16 md traumatrauma	19a. Informant's Name/Relationship (Type, Print) Genevieve E. Inman-wife	9b. Mailing Address (Street and Number or Rura 3201 Canterbury La., I	
or 1 and 1 tem 2 tem 2 tem 2	20a. Method of Disposition 20b. Place		late 20c. Location - City or Town, State
Page ment o ant: if ury or	4 Donation 5 Other (Specify)	top Serv. Corp 4/3,	
Balt permit. Depart Import eny inj	21. Signature of Funeral Service Licensee William G. Date	22. Name and Address of Facility Rucl 1050 York Rd., Tows	k Towson Funeral Home, Inc. son, MD 21204
8760, Sale be executed hysician and the burial-transit dical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Eshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions).  Due to (or as a consequence of the conditions).  Due to (or as a consequence of the conditions).	VIA-	r respiratory arrest, Approximate Interval Between Onset and Death I DAT
Division of Vital Records, P.O. Box 68760, Standard or Attending Physician: The law requires that the death certificate be executed Funeral Director: Aller this certificate has been signed by the attending physician and tell filled in by the funeral director, page 2 should be detached for use as the burial-transit lical Certification: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 1 1 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal decedent of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of death of the pregnant at time of th		23d. Date of delivery  Month Day Year
ds, P uires that signed b id be determed by Pt	Part II. Other significant conditions contributing to death but not resulting CONGESTIVE INEANT GAILL	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
al Records,  The law requires to cate has been signe, page 2 should be completed by	CORONARY ARTERY DISE	752	24a. Was an autopsy findings available prior to completion of cause of
The Tree has page	DIEMENTIA.		autopsy prior to completion of cause of death?  1 □ Yes 2 ☑ No 1 □ Yes 2 ☑ No
of Vital Physician: 1 this certilical ral director, p	25. Was case referred to medical examiner?	26. Place of Death	
Division of Vital Record or attending Physician: The law requir after death. Director: After this certificate has been sid in by the funeral director, page 2 should lertification; To Be Completed	27. Manner of Death 28a. Date of Injury 28t	Outpatient 3 DOA 4 Nursing Hon	ne 5 Residence 6 Other (Specify) 28d. Describe how injury occurred
Sion trendir death. tor: Af the fu	2 Accident investigation	M 1 ☐ Yes 2 No	
Division c tal or Attending P rs after death. al Director: After ed in by the funers Certification;	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Divisio  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tr	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and place, a and/or investigation, in my opinion, death occurre	and due to the cause(s) and manner as stated.  and at the time, date and place, and due to the cause(s)
To the within 2 To the complete	29b. Signature and title of certifier  (IX) IN IN IN IN IN IN IN IN IN IN IN IN IN	29c. License number D 31856	29d. Date signed (Month, Dey, Year) 03/30/2006
10+1	30. Name and address of person who completed cause of death (Item 23: DESH SHARMA, MD 682 S. ATU	a) (Type, Print) D #406 Boll	03/30/2006 AR MD 21014
State Registrar	31. Date filed (Month, Day, Year)  32. Begistrar's Signature	Locales	

			For	State of Maryland	/ Department of Health and	Mental Hygie	ne	
			1 - State Registrar		Certificate of Death		Na 006	10324
	Physici	an -	Decedent's Name (First, Middle, La	st)			Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, giv	JETTILES	4b. City, Town, or Location of Deat	MARCH	4c. County of Death	
	Examin	er	GOOD SAMARI	TAN HOSPITAL	BALTIMORE		A. County of Death	1
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs. las	t birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth	Birth	place (State or Foreign
	Director	į,	218-44-1427	№ 20F 58	Yrs. Months Days Hours Min.	July 20,1	947 Mc	ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Fown or Location	1 = 1		10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show IT wat be notified at	to	Maryland All	AR	altimore			1 XYes 2 □ No
	or 28a	Funeral Director	10e. Street and Number	,	10f. Zip Code	10g.	Citizen of What Cou	untry?
	ath wi	rai	2222 E. O.	iver St.	21213		US	A
	ltems	nue	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> </ol>	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White	
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 👿 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: 12	nak
21215-0036	within 72 hours after ene. than "natural", or Ite	ted	15. Decedent's E (Specify only highest gra	ducation	16a. Decedent's Usual Occupation (Give kind of work done during most of wo	16b.	. Kind of Business/li	ndustry
2	of thin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	TKIII Y	00.	T .
	filed w Hygier other tl	S	17. Father's Name (First, Middle, Last		Maintenance	me (First, Middle, Maid	attic	+ Iransi
Maryland	ld be f ental h ked of ic eve	To Be	GONNO	Fields	Docto	Tof	California /	Machin
ary	2 shoul and M. le marl sumati	۲	19a. Informant's N e/Relationship (	Type, Print) SISET	19b. Mailing Address (Street and Number or Ri	ural Route Number, Cit	ty or Town, State, Zi	p Code)
	and 2 ealth a m 27 le		Ms. Vanesso	1 Roscoe!	5920 Benton He	ights A	ve. Balt	D. Md. 21201
ore	Pages 1 nent of He int: If itan		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		e of Disposition (Name of etery, crematory or other place)	Date 20c.	. Location - City or T	own, State
altimore,	# 문란를 .		4 ☐ Donation 5 ☐ Other (Specif	y) [V]-	t. Carmel 19	2006 D	<u>'undal</u>	K, Ma.
Ba	Depariment Depariment Depariment Depariment Depariment Depariment Depariment Depariment Depariment Department		21. Signature of Funeral Service Licer	1588	22. Name and Address of Facility JOSEPH L. RUSS	Funeral	Home, P.	A.
i i	- 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4		23a. Pan I. Enter the disease, or com	plications that sused the death.	Do not enter the mode of dying, such as cardian	or respiratory arrest,	p. Md. 21	216 Approximate
	Physician		Immediat Cause (Final	one cause on each line.		RCTION		Interval Between Onset and Death
*	/Medical		disease or condition resulting in death)	Due to (or as a consequen				
	Examiner		Sequentially list conditions,	0.		SEASE		
,	ed sit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	nce of):			
	s be executed sician and burial-transit	Examine	that initiated events resulting in death) Last	c Due to (or as a consequen	ice of):			
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burrat-transit		l	d				
9	ng phy	Physician/Medical	IF FEMALE:					
Вох	eath certific attending pl	an/h	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy			23d. Date of deliv	,
	the a	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	h 5 Other (specify)		Month	Day Year
P.0	res that the de signed by the a be detached f			ontributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacc	to use contribute to	the cause of death?
Division of Vital Records,	quires n sign	d by	CARDIDMYOP		ROINTESTINAL	1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
000	aw require s been sig 2 should t	Completed	BLEED END	STAGE RE	ENAL DISEASE	24a. Was an	24b. Were aut	opsy findings available
ž	The lav	mo;				autopsy performed′ 1 ☐ Yes 2 ☑	? death?	ompletion of cause of 2 No
/ita	hysician: The la nis certificate has I director, page 2	Bec	25. Was case referred to medical examiner?			ath [Check only one]		
5	Physic this c	٩	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER		lome 5 Residence		<b>(y</b> )
50	ding Phy th: After thi funeral o	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	b. Time of lnjury at Work?  M 1 Yes 2 No	28d. Describe how in	jury occurred	
<u>IS</u>	r Attending Physician: er death. ector: Atter this certifici by the funeral director.	fica	3 Suicide 6 Could not b	28e. Place of Injury - At home		28f. Location (Street	and Number or Run	al Route Number.
á	s effe	Certification:	4  Homicide determined	building, etc. (Specify)		City or Town, Sta	ate)	
	To the Hospital or Attenwithin 24 hours efter deation to the Funeral Director: completely filled in by the	edical	Chack only 2 Madical Exam	ysician: To the best of my knowle	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause	(s) and manner as :	stated.
	the hin 24 the F	Medi	one) 29b. Signature and title of certifier	and manner stated.				
	7 3 P 8	7	Stuti St	iantar MI	29c. License number  RES 000		Date signed (Month, XRCH 29	
	\	1	30. Name and address of person who	completed cause of death (Item 23	(Type Print)			
				VKAR 5601	LOCHRAVEN BLUE	BALTII	MORE, M	D-21239
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature				

			1- State of Marylan Registrar		irtment of H tificate of L			ene 006	10325
	Physici	an	Decedent's Name (First, Middle, Last)     CHARLES S. JONES, JR.	-			Date of Death     Month	Day Year	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	MARCH	29 200 4c. County of De	
9			St Agnes Healthcare			more	-	N/A	
13.5°	Funeral Director		5. Social Security Number 214-44-9945 6. Sex XIXM 2 F 58	last birthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 11/09/	9. B 1947 M	irthplace (State or Foreign Country) ARYLAND
	/land			ty, Town or Loc	eation				10d. Inside City Limits
	e Man	ctor	MD N/A	BALTIM	ORE CIT	Y			XXYes 2 □ No
	with th	Director	10e. Street and Number 2608 W. FOREST PARK AVENU	(17)	10f. Zip Code		10	g. Citizen of What 0	Country?
	death ms 23	Funeral	11. Marital Status  12. Was Decedent Ever in U. Armed Forces? U.S.		21215 Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-	USA 14. Race - An	nerican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deportment of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show appringing or other traumatic event, the Medical Examinar must be notified at another.	by	1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give Year or Dates:	RMV	Yes, specify Cubai  ☐ Yes 2  ☑ No	n, Mexican, Puerto I Specify:	Rican, etc.)	Specify: B	
5-0	"natu	letec	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa	lurina most of workir	ng	6b. Kind of Busines	
212	s withir ilene. r than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 1 2 T H	MAIN	O NOT use retired, TENANCE	SUPERVI		BALTIMOI GOVERNMI	
	tal Hyg d othe	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, M	aiden Surname)	
ryla	d Men marka matic	L 2	CHARLES S. JONES, SR.  19a. Informant's Name/Relationship (Type, Print)	10h Mailine	Address (Street		NE MCL		7.0.41
Z Z	nd 2 saith an 27 is i		ANTHONY F. JONES / SON			EADE RD.		City or Town, State, IMORE.	MD 21244
Baltimore, Maryland	of Hex of Hex if Item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	Place of Disposi		D.	ate 2	Oc. Location - City of	
Ħ.	it. Pages rtment of l rtant: If It		4 Donation 5 Other (Specify)	<b>XKKTZO</b> I	N FORES'	r O4/0			MILLS, MD
Bal	Dep. Impo		21. Signature of Faneral Service Licensee	1 40	Name and Addres	ERTY HEI	GHTS A	VE, BALT	IOME 21207 IMORE, MD
			23a. Part. Ent. the disease, or complications that caused the deat shock, or eart failure. List only one cause on each line.  Immediate _ause (Final	Do not enter	r the mode of dying	g, such as cardiac or	r respiratory arres	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease condition resulting in death)  Due to (or as a consequence)	WEUI	MONIF				Days
	Examiner		Sequentially list conditions b — — — — — — — — — — — — — — — — — —	coho	Cic Liv	e cin	hosis		Times
	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	ruence of):					Years
oʻ	ficate be executed physician and is the burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a consequ						12013
68760	cate be physici the bu	edical	d						
Box 6		n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant	ancy				23d. Date of de	livery
P.O. B(	The law requires that the death cert le has been signed by the attending age 2 should be detached for use a	Physician/M	in the past 12 months?  1  Yes 2 No 9 Unknown  1 Live birth 2 Fetal 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Month	Day Year
Division of Vital Records, P	quires that n signed b uld be det	by	Part II. Othar significant conditions contributing to death but not resu	ulting in the unc	derlying cause give	n in Part I.			o the cause of death?
6 0 0	law require as been si 2 should b	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available
E		Соп					performe	ed? death?	completion of cause of
<u> </u>	ysician: The vis certificate director, pag	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ 8	ER/Outpatient	3 Do A Othe	26. Place of Death			
n of	ding Phy h. After this funeral d	$\vdash \downarrow$	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	3□ DOA 28c. Injury Work	4 14di Siliy Holl	8d. Describe how	ce 6 Other (Sporinjury occurred	ecify)
Sio	tendir leath. tor: Af the fu	catic	2 Accident investigation		M 1 □ Y	es 2 □No			
DΙΧ	s after of Al Direct al Direct ad in by	Certification:	4 Homicide determined 28e. Place of Injury · At hombuilding, etc. (Specify	ome, tarm, stree y)	et, factory, office	2	8f. Location (Stre City or Town,	et and Number or F State)	lural Route Number,
	To the Hospital or Attending Physician: which a four siter death as a fire death to the Funeral Director: After this certifica completely filled in by the funeral director; p	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my know 2 Medical Examiner: On the basis of examination and manner stated.	wledge, death o tion and/or inve	occurred at the time estigation, in my op	e, date and place, a inion, death occurre	nd due to the cau d at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the To the complete of the the the the the the the the the the	W	29b. Signature and title of certifier	440	29c. License			d. Date signed (Mon	
,	-		30. Name and address of person who completed cause of death (Item	, MD	F / 7	495		03/29/0	<b>6</b>
L	1		SANTAY VINJAMARAM	900 I	caton A	ve, Ba	Chimose	e, MD :	21229
	Sta Registr	_	30. Name and address of person who completed cause of death (Item SANJAY VINJAMARAM)  31. Date filed (Month, Day, Year)  APR 0 4 2006  32. Degistrar's Signat	ture	adi				

CHARLES

JONES,

DHMH 17 Rev 1/2001

Registrar

APR 0 4 2006

Please Type or Print in Black Indelible Ink Fasure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mariken Straub Kessler Apri1 2006 11:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4536 Schenley Road Baltimore
If Under 1 Year | If Under 24 Hrs. N/A Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 XF Yrs Director 196-56-6788 MAR 30. 1964 Ohio Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28e-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturat", or items 23a or 28s-1 show any injury or other treumatic event, Ite Miculcal Examination and once. 1 XYes 2 No Director Maryland N/ABaltimore 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 4536 Schenley Road 21210 USA Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Self-Employed Acupuncturist 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be Richard Ralph Straub Dorothea Elisabeth Karreman 19a. Informant's Name/Relationship (Type, Print) Domestic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21210
Date 20c. Location - City or Town, State Frank Douglas Randak/ Partner 4536 Schenley Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 4/5/06 Baltimore, 21. Signature of Funeral Service treensee

Fdward A. Gregorchik 22. Name and Address of Facility Cremation Society of MD, 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Squamous Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** Year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use es the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) After thi 28b. Time of 28d. Describe how injury occurred 27. Manner of Death t ☑Natural 28c. Injury at Work? Certification: Division Injury 5 Pending investigation 1 □ Yes 2 □ No death. i Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a To the Funerei C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) APR 0 4 2006

Robert B. Donegan,

of certifie

29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6569 North Charles Street, Suite 205 West, Baltimore, M.D

21204

29d. Date signed (Month, Day, Year)

April 3, 2006

29c. License number

D005619

			1 - State of Ma	-	Departmer <i>Certifica</i>			and Ment	al Hygier	4000	1032	8
	Physici		Decedent's Name (First, Middle, Last)					N	ate of Death	Day Year 28 - ZOO		M
	/Medio Examin		4a. Facility Name (If not institution, give street and number)  St Elizabeth Rehab/Nw  5. Social Security Number  6. Sex  7. Age	rsugCa	uter.	Bet	Location o	of Death	id	4c. County of De.	more E	0
	Funeral Director		218-26-4946  Usual Residence of Decedent	74	Yrs. Months	Days	Hours	Min. (A	ate of Birth Month, Day, Yes	ar)	irthplace (State or Fore Country) aryland	ıgn 
	Maryland -f ehow [led al	tor	10a. State 10b. County MD Baltimore	10c. City, Town		timo	re				10d. Inside City Limi	
	or 28a	Direc	10e. Street and Number		10f. Zi				10g.	Citizen of What C	Country?	
920	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show eny Injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	3320 Benson Avenue  11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ▼N If Yes, Give Year or Dates:		13. Was Dece	dent of Hi cify Cuba	spanic Orig n, Mexican Specify:	gin? (Specify ) , Puerto Rican		14. Race - Arr Black, Wh Specify:	nerican Indian,	
21215-0036	d within 72 ho gene. ir than "natur ine Madical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-		Decedent's Usu (Give kind of wo life. DO NOT u	rk done d	luring most )	of working	166.	Kind of Busines	,	
pue	be filed ntal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)						t, Middle, Maid	,		
Maryland	should ind Mer i marke umatic	<sup>C</sup>	Ado1ph Wa1dman  19a. Informant's Name/Relationship (Type, Print)	19b.	. Mailing Addres	s (Street a			Breight te Number, Cit	ner y or Town, State,	Zip Code)	
», M	and 2 lealth a m 27 fa		Robert Knight - Son	-			Road		and the same of th	D 21090		
nore	ages 1 ant of H nt: if ite y or oth		20a. Method of Disposition    X	√ Meado	Disposition (Na y crematory or Wridge	ther place	a)	Date		Location - City o		
Baltimore,	permit. P Departme Importan eny Injur	(	21. Signature Tuner Service Licenses		orial P	nd Addres	s of Facility	3-31-20 Ambrose	Funera	krid e 1 Homeo owne, MD	f Lansdowne	е
	The second		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do n						owne, MD	Approximate Interval Between	
We Allen	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	refle							Onset and Death	les
V	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of consequence of	/-	ley.	eph	oge	a -		4 week	5
8760,	death certificate be executed e attending physicien and od for use as the burial-transit	dicai	Landelina in depart 1 and	consequence o	of):						1	
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 Fetal death	N A 3 Ectopic p 5 Other (s					23d. Date of de Month	elivery Day Year	
ords, P.	The law requires that the ate has been signed by th bage 2 should be detache		Part II. Other significant conditions contributing to death bu	t not resulting in Faul	the underlying of	ause give	en in Part I.		23e. Did tobacc	_	to the cause of death? Probably 4 Unknow	₩n
Vital Record		e Completed by	Hy perteuseon 25. Was cas at red to medical	y Du	slass	2	00 8	1	4a. Was an autopsy performed.  Yes 2	prior to death?	autopsy findings available completion of cause of the completion of cause of the completion of the com	ole of
Ţ	Physicia this certi al directo	To Be	examiner:  1  Yes 2 You Hospital:  1  Inpatier	nt 2□ER/Out	tpatient 3 D	Othe		of Death <i>(Che</i> rsing Home		6 ☐Other (Sp	ecify)	
ou o	ding P h. After ti funera		27. Manner of Death  1 Natural 5 Pending (Month, Day  Accident investigation	Year) In	njury	28c. Injury Work	at N	14	Describe how in	jury occurred		
Division of	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Inju building, etc.	ry - At home, far	V/H			28f. L	ocation (Street ity or Town, St.	and Number or F ate)	Rural Route Number,	
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner state and	examination and	, death occurred d/or investigation	at the tim	e, date and pinion, deat	d place, and d h occurred at	ue to the cause the time, date a	(s) and manner a and place, and du	as stated. ue to the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifier  Slovea Damieu	de	Du	License	Dá	2476	60	Date signed (Mor	106	
	10		30. Name and address of person who completed cause of de	1	Type, Print)	724	1 ma	Eden	Choc	ee hon	e Suite 3	09
	Sta	100	31. Date filed (Month, Day, Year)  APR 0 4 2006	r's Signature	Contes.	exti	mor	e v	na	-1	0	-
DI	Registr	ar	APR 0 4 2006	10 19								

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

APR 0 4 2006

ORIGINAL

				State of Mary				•	_	10000
			1 - State Regist <b>Amend Item #1</b>	1.17&23e Pe	r Physin	tificate of	710/06 JH		. No. UUD	10330
П	Physici /Medic		1. Decedent's Name (First, Middle, Last)	ILTON		ERSH	WA	2. Date of Death Month	Day Year 2006	3. Time of Death 7:02 PM
	Examir		4a. Fecility Name (If not institution, give				or Location of Death		4c. County of Deat	
	Funeral		HARBOR HOSPITS  5. Social Security Number 6. Securi	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	ear Co	nplace (State or Foreign untry)
	Director		217-03-2603 1x	x <sup>M 2□ F</sup> 85	Yrs.	Worth S Days	Prodis IVIII.	March 13	, 1921 Ma	aryland
	aryland show	٦.	10a. State 10b. County  Maryland Anne Aru		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-f	irecto	10e. Street and Number	nder	gren pur	10f. Zip Code		10g	. Citizen of What Co	
	s 23a o	rai D	1628 Bedford Road				061		USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show says injury or other treumatic avant, if is Medical Examitive resulting at ADGE.	Completed by Funeral Director	11. Marital Status  +	12. Was Decedent Ever Armed Forces? 1½ Yes 2 □ No If Yes, Give Year or Dates 1942		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2/10XNo	Hispanic Origin? (Spec pan, Mexican, Puerto F Specify:	offy Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:	
<u>5</u>	"natur	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced	dent's Usual Occu	pation during most of workin	9 16	b. Kind of Business/	industry
212	d withir giene. er then	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		tionary	Engineer		MVA	
and	t be file ntel Hy ed oth	Be	17. Father's Name (First, Middle, Last)  Milton Kershaw	Charles Mi	lton Kor	char	18. Mother's Name Mae	(First, Middle, Ma Romeo	uiden Surname)	
Maryland 21215-0036	should and Me smark sumation	ဥ	19a. Informant's Name/Relationship (Ty				t and Number or Aural		City or Town, State, 2	ip Code)
e) S	1 and 2 Health am 27 i		Myrtle Kershaw  20a. Method of Disposition	Wife	Db. Place of Dispo		ord Road,		nie, MD 21	
mor	Pages lent of I nt: if its ry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	amount from State	cemetery, crer Maryland	natory or other pla	ice)	2	rrison For	
Baltimore,	permit. Departming imports any inju		21. Signatére of Juneral Service Licens	. Hens	22	Name and Address Burgee-He	ess of Facility enss—Seitz 1s Road, B	Funeral	Home, Inc	. 21211
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or leaf failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the cle cause on each line.  LUNG C  Due to (or as a cor	ANCER	er the mode ol dyi	ing, such as cardiac or	respiratory arres	t,	Approximate Interval Between Onset and Death FARS
	cate be executed physicien end the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor						
Division of Vital Records, P.O. Box 6	Attending Physicien: The law requires that the death certificate robath.  robath.  sctor: After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ i 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify) _	·y		23d. Date of deli Month	very Day Year
rds, P	quires that an signed b uld be deta		Part II. Other significant conditions cor	ntributing to death but not	t resulting in the u	nderlying cause gr	ven in Part I.		cco use contribute to	
l Reco	The law re sete has bee page 2 sho	Completed						24a. Was an autopsy performe	prior to death?	topsy lindings available completion of cause of
Zita Zita	sician: s certific lirector,	Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:	2 ER/Outpatien	t 3□ DOA Ot	26. Place of Death		ce 6 ☐Other (Spec	4.1
ion of	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	ation: To	27. Manner ol Death  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Inju Wo		8d. Describe how		uy)
	- 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp		eet, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital o within 24 hours af To the Funeral D completely filled in	Medical	one) 2   Medical Exami	sician: To the best of my ner: On the basis of exar and manner stated.	knowledge, death nination and/or in	occurred at the ti vestigation, in my	ime, date and place, as opinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	MTERN		29c. Licen	se number		I. Date signed (Mont! IRCH, 29	
in	16		30. Name and address of person who co	mpleted cause of death		Print)				1 2006
10	Sta	to	RAGHAD JALIL 31. Date filed (Month, Day, Year)	3001 Sout	ionature		BALTIMO	DRE, MIC	21225	
3	Registr		APR 0 4 20	06 Jaggero	Di As	artes				

			For State Registrar	State of Ma	-	artment of I rtificate of		d Mei	ntal Hygier	. 000	0331
	Physici /Medic		1. Decedent's Name (First, Middle, Last)		KK	Ygier		2. M	Date of Death Month HRCh 2	9 2006	3. Time of Death 4.31P M
	Examin		4a, Facility Name (If not institution, give s BALTIMORE VA / 5. Social Security Number 6. Sex	Medical !	Conter (In yrs. last birthday	1011-1	MORR	_		4c. County of Deat	n nplace (State or Foreign
	Funeral Director			M 2 🗆 F	85 Yrs.	Months Days	Hours M	Min. M	Date of Birth (Month, Day, Ye. BYCH 3,	1921 Mary	Tand
	Maryland -f show	tor	10a. State 10b. County N/A		10c. City, Town or L Ba	ocation 1timore (	City	<u> </u>			10d. Inside City Limits  XXYes 2 ☐ No
	with the	Direc	10e. Street and Number 625 S. Linwood Ave	nue		10f. Zip Code	1224			Citizen of What Co	•
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23e or 28e-f show or other traumatic event. The Medical Eval, for minit to notified at	by Funeral Director		12. Was Decedent E Armed Forces? 1, Yes 2 No hYes, Give Year or Dates: W		Was Decedent of I If Yes, specify Cub	Hispanic Origin pan, Mexican, P	? (Specification Rice	y Yes or No-	14. Race - Ame Black, White	ńcan Indian,
21215-0036	d within 72 ho giene. ir then "natur. I're Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	16a. Dece (Give life.	edent's Usual Occu e kind of work done DO NOT use retire ecurity	during most of	f working	16b	Kind of Business/	•
Maryland	2 should be filed within and Mental Hygiene. is marked other than sumatic event. I'm III.	To Be C	17. Father's Name (First, Middle, Last) Joseph Krygi	er			18. Mother's Kath		irst, Middle, Maid Berry	len Sumame)	
	and 2 should saith and Men n 27 is marka		19a. Informant's Name/Relationship (Ty, Katherine B. Goddar			ing Address <i>(Stree</i> )				y or Town, State, Z e, MD 212	
Baltimore,	permit. Pages 1 and 3 Department of Health Important: If itam 27 any injury or other tra		20a. Method of Disposition  1 🖫 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signatury of Furtheral Sey 1, 27 Center		Holy Ro	matory or other pla Sary 2. Name and Addro	ess of Facility		2006 B 5305	altimore, Harford F More, MD	, MD Road
	Pnysician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused to cause on each line	HS						Approximate Interval Between Onset and Death
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68760,	icate be executed physician and s the burial-transit	dlcai	resulting in death) Last	Due to (or as a	consequence of):						
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	iclan: The law requir certificate has been si ector, page 2 should	Completed							24a Was an autopsy performed	prior to death?	topsy findings available completion of cause of 2 No
Vital	Physiclan: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		Ot	her		Check only one)		
of	Phys this ral dir	٠ <u>۲</u>	1 ☐ Yes 2 ☑ No	1 Linpatien 28a. Date of Injury		nt 3 L DOA	4   Nursii	-	5 🗀 Residence	6 □Other (Special of the following occurred of the following occurred of the following of	city)
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Div	To the Hospital or Attand within 24 hours after death To the Funaral Director: completely filled in by the		4 Homicide determined  29a. Certifier 1 Certifying Physics	building, etc.	(Specify)				City or Town, St	ate)	
	s Hos 24 h a Fun letely	Medical		ner: On the basis of and manner state	examination and/or is						
	To th withir To th comp	Me	29b. Signature and title of certifier	,	-	l l	se number			Date signed (Monti	
)	/ VI		Turk	lan	MO	1719	675		3	31/06	
3	5 1		O. Name and address of person who co		O NORTH	GREENE	Stree:	+BA	actimo R	Le MD &	4201
•	Sta	ite .	31. Date filed (Month, Day, Year)	32. Registrar	's Signature						

		1 - Stete Amend Item Registrer		r.,G853,94		Death			16	10337
Physici	an	1. Decedent's Name (First, Middle, Las	•				2. Date of Death Month 03	10ay 20	(ear	3. Time of Death
/Media	cal	Berthold Kaufman  4a. Facility Name (If not institution, give			4h City Tourn or	Location of Death	03	4c. County of		9:19p M
Examin	ier	Washington Hospi	_	r	-	a Park		Mont		ry
Funeral Director		5. Social Security Number 6. Security Number 6. Security Number 1	TT SURE	e (In yrs. last birthday, 97 Yrs.	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 04-04-	Year) -1908	9. Birthpla Count Ge	ace (State or Foreig ry) rmany
and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10	d. Inside City Limits
Maryla febo	ō		omery		Spring					1 ☐ Yes 2 <b>∑</b> (No
7.28a-	rec	10e. Street and Number			10f. Zip Code		10	Og. Citizen of Wh	at Count	ry?
h with	a D	9039 Sligo Creek	Pkwy #70	8		20901		USA		
s 1 and 2 should be filed within 72 hours after death with the Maryland if Heelth and Mental Hygiene. Item 27 is markad other then "natural", or Iteme 23e or 28a-f ehow other traumatic avent, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2424 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	White, e	itc.
72 ho	ted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation	'ng	16b. Kind of Bus	ness/Ind	ustry
within within the with	Completed	Elementary/Secondary (0-12)	College (1-4or 5	ife.	DO NOT use retired	)	'ig	77	- /A-	. 1
e filed w il Hygier other th		47. Satisfact Name (Since Addition (1994)	2+	Dai	ry Farmer	40 Mah M	/5 A A 6: delle - A		<u> </u>	riculture
uld be fi Aental H rkad ot tic aver	Be	17. Father's Name (First, Middle, Last)  Max Kaufmann				18. Mother's Name	Kemmeri			
2 should be and Mental is marked aumatic av	မ	19a. Informant's Name/Relationship (7	vne Print)	19h Mail	ing Address (Street a				tate Zin	Codel
and 2 seeth an n 27 ts		Herbert W. Kaufn			5 Sligo C					16
S 1 ar f Hee f Hee other	1 8	20a. Method of Disposition	<del></del>	20b. Place of Disp				20c. Location - C		
Page: ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ke Cremat		9-2006	Beltsv	ille	, MD
permit. Pages Depertment of I Important: If Ite any Injury or or once.		21. Signature of Suneral Service Licen	s <del>ee</del>	1263	2. Name and Addres Rapp Fune 933 Gist	ral & Cre	mation S Spring	Service MD 2091	0	
Physician / Medical branched and branch-transit sthe purial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	iopulmonar a consequence of): a consequence of): a consequence of):	Artery (					Onset and Death
death certii e attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Monti		y Day Year
tuires that the de n signed by the a uld be detached t	Ď	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	inderlying cause give	on in Part I.				e cause of death?
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sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:		nt all DOA Othe	26. Place of Death				
Phys rathis	5	1 ☐ Yes 2☐No 27. Manner of Death	i ( <u>X</u> inpane		III SLI DOA	4 Linuising Hor	me 5 Reside 28d. Describe ho			)
ding l th. After funer	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da	y Year) Injury	Worl	r? Yes 2 □ No		,,		
ol or Attending Physicien: efter death. Director: After this certification by the funeral director,	Certification;	3 Surcide 6 Could not be determined	28e. Place of Injuding, et	ury - At home, farm, st c. (Specify)			28f. Location (Str City or Town		or Rural	Route Number,
To the Hospitel or within 24 hours effe To the Funeral Dir completely filled in	Medical C	29a. Certifier 1 Certifying Ph	ysi nan: To the best liner: On the basis of and manner sta	of my knowledge, dea t examination and/or in ated.	th occurred at the time	ie, date and place, a pinion, death occurre	and due to the ca	use(s) and mannate and place, an	ner as sta d due to	ited. the cause(s)
To the within To the Complex	Me	29b. Signature and the of certifier	0		29c. License	number	29	9d. Date signed (	Month, D	Day, Year)
		* HVM	16		D00	59428		03-26-2	006	
(3)		30. Name and address of person who can Robert Hedstall	completed cause of d 7600 Carr	leath (Item 23a) (Type coll Av Tak	Print) coma Park	MD 20913				
Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 2006		ar's Signature	9					

			For State Registrar	State of M	laryland		artmen rtificate				lental Hy	/giene Reg. No.	06	0333
			1. Decedent's Name (First, Midd	le, Last)				-			2. Date of De Month	eath Day	Year	3. Time of Death
	Physici /Medic		Marian	Α.		Κι	ıczins	ski			March	29,	2006	9:00 A <sup>M</sup>
	Examin		4a. Fecility Name (If not institution	n, give street and number	)		4b. City,	Town, or	Location of	of Death		4c. Cd	ounty of Deal	th
н			797 Jennie Dri	ve			Seve					Ann	e Arui	
	Funeral		5. Social Security Number	6. Sex 7. A		ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)		hplace (State or Foreign ountry)
	Director		215-24-1915		77	Yrs.					May 11	, 1928	Md.	
	and *		Usual Residence of Decedent  10a. State 10b. County	/	10c. City	y, Town or Lo	cation							10d. Inside City Limits
	f sho	5	Md. Anne	Arude1	Seve	rn								1 ☐ Yes 💥 ☐ No
	28a-	rect	10e. Street and Number	212 0002	Beve		10f. Zip	Code				10g. Citize	n of What Co	puntry?
	Mith Sa or	Ö	797 Jennie Dr	ive			2114					U.S	Δ	
	within 72 hours after death with the Maryland ene. than "natural", or liems 23a or 28a-f show Ira Madical Examilier mast be mailfied at	Completed by Funeral Director	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13.			spanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)		. Race - Ame	
	r Iter	F	1 ☐ Never Married 2 ☐ Mai								Rican, etc.)	i	Black, Whit	
036	urs a	þ	3 Midowed 4 ☐ Divorce	If Yes, Give Year or Dates:			1 ☐ Yes	2 KN No	Specify:			S	pecify: WI	nite
21215-0036	72 ho	ted	15. Deceder	nt's Education est grade completed)		16a. Dece	dent's Usua	l Occupa	ition	t of work	rina	16b. Kind	of Business	Industry
21	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of wor DO NOT us	se retired,	)	. 0, ,,,,,,				
21	filed with Hygiene. other than	Co	12			Waitı	cess						ling	
nd	tal High	Be	17. Father's Name (First, Middle,	, Last)							e (First, Middle		imame)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "netural", or Items 23a or 28a-1 show item 27 is marked other than "netural", or Items 23a or 28a-1 show other traumatic event, Ite Mandeal Examilier at	ဥ	James Barry								Parris			
lar	2 sh and is m		19a. Informant's Name/Relation			1	•	•			al Route Numb	•	own, State, A	Zip Code)
	and iealth m 27 her tu		Mr. Dan Kuczin	ski / Son	Joon Di	796 I			l Sev	ern,	MD. 21		tina City as	Taura State
O.	Pages 1 nent of H int: If ite ury or ot		20a. Method of Disposition	3 □Removal from State	1 0	emetery, crei	matory or o	ther place		Apr			tion - City or	
Ē	men tant: jury		*4 □Donation 5 □ Other (		Gle	n Have				2006			Burni	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trae		21. Signature of Funeral Service	Licensee		1170	2. Name an							ome, P.A.
	70 = 4 O	- 0		11/6	-Mole	1					Glen 1		, MD.	Z1U61 Approximate
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	ine. ARD	DAL			cti	i i	or respiratory a	311651,		Interval Between Onset and Death
8760, 🗷	requires that the death certificate be executed sen signed by the attending physician and nould be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c										
P.O. Box 6	uires that the death certifics signed by the attending ph Id be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal	Ideath 3	⊒Ectopic pr ⊒ Other <i>(sp</i>					230	d. Date of del Month	ivery Day Year
	s that ned b	by Pi	Part II. Other significant condit	ions contributing to death	but not resu	ulting in the u	nderlying c	ause give	en in Part I		23e. Did	tobacco use	contribute to	the cause of death?
rds	quire n sig uld b										10	Yes 2	No 3⊕Pí	obably 4 Unknown
Records,	elaw hasb je2st	Completed									24a. Was auto perf		prior to death?	utopsy findings available completion of cause of
ita	ician: Th certificate rector, pag	ВеС	25. Was case referred to medical examiner?	al				-	26. Place	of Deat	h (Check only	one)		
of Vital	di S	70 6	1 ☐ Yes 2 ☐ No	Hospital: 1 🗆 Inpat	ient 2 🗆	ER/Outpatier	nt 3 DC	Othe	er: 4□Nu	ursing Ho	ome 5 Aes	idence 6	]Other (Spe	cify)
0 _		Ë	27. Mann 3 of Death 1 ─Natural 5 ☐ Pendi	28a. Date of In- (Month, D	ury ay Year)	28b. Time o Injury	f 2	8c. Injury Work	at		28d. Describe	how injury o	occurred	
Ö	Attending r death. sctor: After by the fune	atio	2 ☐ Accident invest	tigation			М	101	Yes 2□	No				
Division	r Att ter de irect	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place of I	njury - At ho etc. <i>(Specif</i> y		reet, factory	, office			28f. Location ( City or To	(Street and I own, State)	Vumber or Ri	ural Route Number,
0	ital o	S												
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		ing Physicien: To the bes I Examiner: On the basis and manner s	of examinat									
	To the within To the Comp	ž	29b. Signature and title of certific	er n C			290	. License	number	a i				h, Day, Year)
Ì				Teler.	1	~>	1	ノイ	404	7/		05	- >1	-2006
	10		30. Name and address of person	who completed cause of	death (Item		Print)	ed	Ld	Lin	th.cum	- mal	21	090
	Sta	ite	31. Date filed (Month, Day, Year	7) 32. <b>39</b> 9is	trar's Signa	iture		4	<i>y</i> —					
	Regist	ar	APR 0	4 2006	1000	S A	MALL	,						

			For State Registrar	State of Maryland	-	rtment of He tificate of D			giene Reg. No. 0	6	0334
			Decedent's Name (First, Middle, Last)					2. Date of De.		Year	3. Time of Death
	Physicia /Medic		John Edward	Kaufman				March	30,200	6	1250P M
Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	Examin	er	4a. Facility Name (If not institution, give s Washington County			4b. City, Town, or Hagersto		eath	4c. County	or Death Lingto	'n
_	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Year	If Under 24 h	trs. 8. Date of Bird Min. (Month, Da	th		ace (State or Foreign ry)
	Director		220-05-9419	M 2□F 86	Yrs.	Months Days	Hours	May 4,	1919	Mary	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation				10	d. Inside City Limits
	Many Ind	tor	Maryland Harford	For	rest F	1111					1 ☐ Yes 2X No
	th the	lirec	10e. Street and Number	1 10		10f. Zip Code			10g. Citizen of V	Vhat Count	ry?
	ath wi	ral	1716 K Landmark Dr		1	21050-3			USA		
	72 hours after death with the Maryland natural; or Items 23s or 28s-f show jical Espains Invelte inclified at	Funeral Director	11. Marital Status  1 ☐ Never Married 2 🕱 Married	2. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No	. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	- 14. Hac Blac	e - America ck, White, e	
036	ours af		3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: WW I	I 1	☐ Yes 2 XNo	Specify:		Specify		ite
5-0	72 ho	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	ent's Usual Occupa kind of work done d	uring most of	working	16b. Kind of Bu	ısiness/Indi	ustry
121	within ene. then "	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use retired) _esman			Bake	Y7.7	
<u>q</u>	e filed with Il Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		Jas		18. Mother's	Name (First, Middle,			
ylar	should be and Mental marked o	To B	Frank (unk	) Kaufi	man	]	Floren	ce (u	nk)	Har	rington
Maryland 21215-0036	C1 60 75 60		19a. Informant's Name/Relationship (Type					r Rural Route Numbe			
	1 and Health tem 27		Anna M. Kaufman -  20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of		ve, Forest	20c. Location -	MD 21 City or Tov	050-3192 vn, State
ē	Pages nent of int: if it		1   Burial 2 □ Cremation 3 □ Real Section 2 □ Real Section 3 □ Other (Specify)	emoval from State	netery, cren KWOOd	cem.	I .	/03/06	Baltimo	re, M	arvland
Baltimore,	permit. Page Department Important: if any injury o		21. Signature of Funeral Service License	96		Name and Address	s of Facility	McComas	Funeral	Home	, P.A.
	20199	113	1 ( ussell Sly								land 21014
			23a. Part1. Enter the disease, or complications, or heart failure. List only on immediate Cause (Final	e cause on each line. '				diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	SEP'11C	nnce of):	HOCK				2	weeks
	Examiner		Sequentially list conditions b	SEPTIC Due to (or as a conseque PNEUN	ON	14				4	L weeks
7	sit ad	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ince of):					1	
V	xecution and al-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ince of):						
68760,	ficate be executed physician and s the burial-transit	dicai	d								
	artifica ing ph e as th		IF FEMALE:	0.00			17				
Вох	leath certifi attending   I for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	leath 3	Ectopic pregnancy Other (specify)				te of deliver inth [	y Day Year
P.0.	that the de ed by the detached	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		Other (specify)					
	law requires that the death certif as been signed by the attending 2 should be detached for use a	by P	Part II. Other significant conditions con								e cause of death?
ord	w requires tha been signed I should be det	ted	P>EU	bomembra eimer's DE	NOY	COLIT	15		Yes 2 □ No	3 Proba	ably 4 Unknown
Division of Vital Records,	e law has b	Completed	#12h	eimers DE	ME	NIIA		24a. Was	osy	Were autop prior to com death?	sy findings available apletion of cause of
la	ician: The l certificate ha rector, page	e Co	25. Was case referred to medical				26 Place of	1 ☐ Yes  Death (Check only of	200 No		2 No
Ž		To B	examiner?	ospital: 1 Inpatient 2 ☐ E	R/Outpatien	t 3□ DOA Othe	ACT.	ng Home 5 ☐ Resi		er (Specify	)
O L	ing Ph		27. Manner of Death  1 Natural 5 Pending		8b. Time of Injury	28c. Injury Work		28d. Describe	how injury occur	red	
isio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	28 e. Place of Injury - At hom	a farm str		res 2 □No	28f Location (	Street and Numb	per or Rural	Route Number
Div	i or Attend after death Director:	Certification:	4  Homicide determined	building, etc. (Specify)	10, Iaiiii, Siii	ser, lactory, office		City or To	wn, State)	or or riurar	Troute Trumber,
	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.	edicai C	(Check only 2 Medical Examin	sician: To the best of my know ter: On the basis of examination	ledge, death	occurred at the time	e, date and p	lace, and due to the	cause(s) and ma	anner as sta	ated. the cause(s)
	To the h within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.		29c License	number		29d Date sinne	d (Month C	Day Yearl
			1 Com	2		14	4996		March	30	,2006
	104		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print) / alla		Boons ba	EN MA	2.1	7/2
	10.					cappai	ns rq	מסי צו וששבון	W 17 D	-/	. ( )
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 4	32. Redistrar's Signatu	II O FA	MARL					

			1 - For State Registrar	State of Maryla		artment of H			ZUUb	10335
,	2		Decedent's Name (First, Middle, Last)			inicate of t	Journ	2. Date of Dea	teg. No.	3. Time of Death
	Physici /Medic		SOFYA K	RAYTA	1AM			Marc	h 31 200	
	Examin		4a Facility Name (If not institution, give		(	4b. City, Town, or	Location of Deat		4c. County of D	
		4	Northwest	HOSPIT	al	Kand	alls-	town	Balt	IMOVE
	Funeral		5. Social Security Number 6. Sec		s. last birthday)  Q/I Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth Month Day	9. I	Birthplace (State or Foreign Country)
	Director		219-35-2486	Χ	84 Yrs.		<u> </u>	001.13	,1921	UKRAINE
	yland now		10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	B Mar	ctor	MD BALTI	MORE	OWIN	IGS MILLS				1 ☐ Yes 2 📉 No
	ith the	Director	10e. Street and Number			10f. Zip Code		1	log. Citizen of What	•
	eth w	rai	4 MELISA COURT				21117			USA
	ter de Items	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
980	urs af	by	3 ₩ Widowed 4 Divorced	1 □ Yes 2 ሺ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE
21215-003	within 72 hours after deeth with the Maryland ene. then "nstural", or Items 23a or 28a-f show is Modical Examiner must be notilited at	Completed	15. Decedent's Edu (Specify only highest grade			dent's Usual Occupa		dein	16b. Kind of Busine	ss/Industry
2	ithin 7 99.	npie	Flementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	iuring most or wo	rking	MEDIAN	
	led w lygien her th	Cor		+	PHYS	SICIAN			MEDICAL	-
Maryland	ntal Hed ot	Be	17. Father's Name (First, Middle, Last)  IOSIF		V D A V	TMAN		ne <i>(First, Middl</i> e, <i>i</i> J	Maiden Sumame) KRUPNIK	
څ	should nd Me mark matic	스	19a. Informant's Name/Relationship (Ty)	oe Print)		TMAN	SARAI		r, City or Town, State	Zin Codel
	nd 2 salith ar		SERGEY KANTSEVOY	-		-			5. MD 2111	
ē,	s 1 ar		20a. Method of Disposition	206	. Place of Dispo	sition (Name of	1		20c. Location - City	
more,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "nstural", or items 23a or 28a-f show any injury or other traumatic svent, the Modical Examiner must be notified at one.		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory or other place HEBREW (		02/2006	REISTERS	STOWN, MD
a	permit. Departminimporte		21. Signature of Funeral Service License			. Name and Addres	The second second second		SON & BROS	
<u> </u>	8 9 E 8 9		Kouto	home	2   2	900 REIST			PIKESVILLE	•
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the de e cause on each line.	ath. Do not ent	er the mode of dying	g, such as cardiad	or respiratory arr	est,	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	AS DU	a-10	n pne	zumo	nia		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):					73.
		-	Securitally list conditions, if any, leading to immediate	Due to (or as a conse	acuence of					
1	nsit	nIne	Cause (Disease or injury	500 to (51 tis a 50113t	aquanta or).					
v Č	be executed sicien and burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a conse	equence of):					
8760,	cate be executed physicien and the burial-transit	dicai								
9		Med	IF FEMALE:							
Box	death certifi e attending i id for use as	ician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe	nancy tal death 3 [	Ectopic pregnancy			23d. Date of o	
0	at the deg by the a tached fe	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5	Other (specify)			Month	Day Year
٦.	res that the Igned by be detact	Physi	Part II. Other significant conditions con	tributing to death but not re	esulting in the w	nderiving cause give	n in Part I	23a. Did tol	hacco use contribute	to the cause of death?
ecords,	uires I signi Id be	d by			<u> </u>	rasily ing saudo giro	on an earth			Probably 4 2 Unknown
Ö	w requir been sl should l	lete						24a. Was a	-	autopsy findings available
<b>4</b>	The law requires that set has been sland by page 2 should be detailed.	ompleted						autops perforr	πe⊈? death	
Vital R		O	25. Was case referred to medical				26. Place of Dea	th (Check only on	2 No 1 Y	es 2 / No
	nysic nis ce direc	To B	examiner? 1 ☐ Yes 2 Ø No H	ospital: 1 Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe	ar-	25.00	ence 6 ☐Other (S	pecify)
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe ho	ow injury occurred	
<u> </u>	Attendi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		1		res 2 □No			
Division	or At after of Direction by	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (St City or Town	reet and Number or n, State)	Rural Route Number,
_	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 12 Certifying Phys	ician: To the best of my ki	nowledge death	occurred at the tim	e date and place	and due to the co	auso(s) and manner	as stated
	24 to 124	Medical	(Check only 2 Medical Examination)	er: On the basis of examinand manner stated.	nation and/or inv	estigation, in my op	pinion, death occu	rred at the time, da	ate and place, and o	lue to the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	, 11	11.	29c. License	number	2	9d. Date signed (Mo	onth, Day, Year)
			pristine Ko	Juhi Haces	stales	1 629	712	1	Jarch	312006
	2		30. Name and address of person o	npleted car'se of leat (Ite	эт 23а) (Тура,	Print)	10	, ,1	)	1 1 1
			Christine Kaju	61 5401C	of Co	urtko	ad Kai	ndalls	town	lary and
	Sta Registra		31. Date filed (Month, Day, Year) J APR 0 4 201	32. Registrar's Sign	lature	P 80 -				•
	100,011									

ORIGINAL

State Registrar

DHMH 17 Rev 1/2001

OCME 10/2003

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a)





O.C.M.E.

April 3, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Americal Trend 10c per 1h 8854 4-5-06 Vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Veal eddun **Physician** 12:15 AM March 2006 izabeth 24 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Elizabeth ent ursing Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M ACKE 214-12-4060 Yrs. 85 Nov. 1920 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at Arbutus 1 ☐ Yes 212 No MD Baltimore Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3320 Benson Avenue 21227 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or Items 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Example 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Credit Manager Montgomery Ward 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Frank Benner Martha Mary Tipperman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Darryl Lynn Taylor 7642 Vista Rd. Elkridge MD 21075 20b. Place of Disposition (Name of cometery, crematory or other place)
Loudon Park Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition \*EBurial 2 Cremation 3 Removal rom State 3-29-2006 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Ignature of Funeral S rviv Lice se-Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Vears Priysician oronary disease or condition resulting in death) /Medical Due tp (or as a consequency of): Examiner 1111 monon eavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine envi burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) attending physicien for use as the burial Division of Vital Records, P.O. Box 68760, Physiclan/Medlcai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be a þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙋 Ûnknown pleted Vascular 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an a cci dent autopsy Com 1 ☐ Yes 2 ☐ No rena 2. No this certificate hroni 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification; To After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 | Homicide within 24 hours after To the Funeral Direct 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 death (Item 23a) (Type, Print) 30. Name and address of person who completed cause Baltimore Avenue Senson 32. Pegistrar's Signature 31. Date filed (Morth, Day, Year) State

Registrar

APR 0 4 2006

			For State	State of Man				nd Me		(")	one	1022	Ω
			Registrar		Ce	rtificate of	Deam		Date of Deat	eg. No.	UUO	1000	0_
	Physici	an	1. Decedent's Name (First, Middle, Last)					-	Month	Day	Year	3. Time of Deat	
	/Medic		VINCENZA		)GSTON				3	31	2006		
}	Examin	er	4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,	or Location of	Death		4c. C	County of Dea	itn	
Е					HOSPITAL	BAUTIM If Under 1 Year		CIT A Hrs. C			0.0	db - 1 / Cd - 4	
	Funeral		5. Social Security Number 6. Sex 212-30-0049	7. Age (	In yrs. last birthday) 80 Yrs.	Months Days		Min.	Date of Birth (Month, Day,	Year)	_ C	rthplace (State or For	eign
	Director		Usual Residence of Decedent		80			(C	tober 14	194	o Mai	ryland	
	and w		10a. State 10b. County	1	Oc. City, Town or Lo	ocation						10d. Inside City Lin	nits
	Mary feb	ō	Maryland Baltimore	e	Dundal	.k						1 ☐ Yes 2 <b>X</b>	No
	158 288 P	Director	10e. Street and Number			10f. Zip Code			1	0g. Citiz	en of What C	ountry?	
	Sa or		7114 Eastbrook Ave	mue			21224	Į.		US	SA		
	death with the Maryland ms 23a or 28a-f ehow	Funeral		12. Was Decedent Eve	er in U.S. 13.	Was Decedent of If Yes, specify Cu			y Yes or No-		4. Race - Am	erican Indian,	
^		Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💆 No				Puerto Ric	an, etc.)		Black, Wh		
15-0036	hours after death with the Marylan tural, or items 23s or 28s-f show at Examirer mast be mailfied at	þ	3 MWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	o Specify:				Specify: Wi	nite	
Š	프 프 플	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occu	pation	of working		16b. Kin	d of Busines:	s/Industry	
7	filed within 72 Hygiene. sthar than "nat	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retir	ed)	or working					
7	ed within giene. er then	Son	12 years	4 years		<u> </u>						County	
Maryland	be filed stat Hygi od other	Be	17. Father's Name (First, Middle, Last)					,	First, Middle, I M. Ont		,		
<u>X</u>		ဥ	Santi DiNoto				COLIC		TI. OIIC				
<u>a</u>	ss 1 and 2 should of Health and Mei item 27 ie mark other treumatic		19a. Informant's Name/Relationship (Ty			ing Address (Stree							
_	and ealth n 27		Landie Callanan	Daughter		South Ty							
9			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Dispo cemetery, cre Sacred Hear	matory or other pl	ace) A	$\mathtt{pri}^{Pat}$	4,			r Town, State	
Ě	Pages ment of ant: If it ury or o		4 ☐ Donation 5 ☐ Other (Specify)				j	2006			alk, M		
Baltimore,	permit. Page Department Important: It any injury o		21. Signature of Funeral Service License	- (	20. 2	2 Name and Add Connelly 7110 Sol	ress of Facility Funera	al Hon	ne of I	Dunda	alk.P.	Α.	
_	70 E E 9		Cothony	onnel							alk,MD		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	ne deá <del>th</del> . Do not en	ter the mode of dy	ring, such as o	cardiac or ri	espiratory arr	est,		Approximate Interval Between Onset and Death	1
	Physician		Immediate Cause (Final disease or condition	UROS	FPSIS							10 DAYS	
10	/Medical		resulting in death)		consequence of):								
	Examiner		Sequentially list conditions,		CARDIT	15						S DAJS	
/	P #	iner	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of).							ZNA	
X	ecute and trans	Examine	that initiated events resulting in death) Last	PNEUMC	consequence of):							TOAYS	
ŠČ,	cien a	E	Todaming in dodain, sad.	Due to (or as a t	consequence on:							1	
8760	The law requires thet the death certificate be executed ate has been signed by the attending physicien and page 2 should be dateched for use as the burial-transit	dicai		J									
φ X	eath certific attending p for use as	/Me	IF FEMALE:	3c. If yes, outcome of	pregnancy						04 5-4-44		
Box	ath c	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnan	су			2	3d. Date of de Month	Day Year	
O	by the de	sic	1 Yes 2 No 9 Unknown	4□Pregnant at tir 9□Unknown	me or death 5 L	Other (specify)							
ع	het ti ad by dated	F	Part II. Other significant conditions cor	tributing to death but	not resulting in the u	underlying cause o	oven in Part I.		23e. Did to	bacco us	se contribute	to the cause of death	?
JS,	ires thet signed t	d b	COROMARY A	ATERV	DISEAS		,		1 1 7	es 2[	]No 3□F	robably 4 Unkne	own
Ö	w require been si	etec	CONDIO MICE	, =(0, -)	0,00						0.00		
şec	: The law cate has I	Completed	DEMENTIA						24a. Was a autops perfori	sy	prior to death?	utopsy findings avail- completion of cause	of
<u> </u>	cate		ANGLOEDEMA	·					1 Yes	2 X No	1 ☐ Ye	s 2□No	
ĬĬ.	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		10	Mac		Check only or	-			_
5	Phys this al dir	-T	1 Yes 2 No	1 X patient		nt 3 DOA	4 □ Nur		5 Reside			ecify)	
ב	ding P. h. After tunera	lo	t\☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	Year) Injury	W	ork? □Yes 2 □ N		u. Describe in	ow injury	occurred		
S	death death tor: the	icat	3 ☐ Suicide 6 ☐ Could not be	290 Place of Injun	u - At home farm st				Location (S	troet and	Number or F	Rural Route Number,	
Division of Vital Records,	or Att	Certification:	4 Homicide determined	building, etc.	y - At home, farm, st (Specify)	areet, ractory, offici	0	201	City or Town		, volinoer or r	iorar rigulo riuliibel,	
_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the tuneral director.		29a. Certifier 1X Certifying Phys	sician: To the best of	my knicylodno don	th penumed at the	tirms date and	Ordanii (an)	fidua nemara	dissidel	neut et minuse e	e statut	-
	To the Hospitel within 24 hours of To the Funerel I completely filled	Medical		ner: On the basis of e	xamination and/or in								
	o the o the omple	Me	29b. Signature and title of certifier			29c. Lice	nse number		2	9d. Date	signed (Mor	nth, Day, Year)	
	⊢≯⊢ŏ		Molning	4.8		Re	2 0	00	-	3/21	106		
,			30 Name 201 201 201	ompleted cause of dea	th (Item 23a) /Tu		5 0			11 31	100		
	$\varphi$			140	BELT ST		MORE	MF	71	230			
	Sta	tá	JEGO BELARO ( 31. Date filed (Month, Day, Year)	32 Registrar		1046	1000	14	<i></i>	-00			
6	Regist		APR 0 4 200	6 80000	OF ASS	SAGE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year A N **Physician** ZILATTA GRACI 900P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2825 CHARLS HARFORL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 21€ F Yrs. MARCHITAGOD IARY And Director 15 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo MARYENO HARFOR FALLSTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code HARL 21047 9892 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 11 Marital Status Black, White, etc. filed within 72 hours after I ☐ Yes 252 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) infant intaint 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked o ATHERIOR Ann ARMSTROOL 1 imoth) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) FALLSTON MARYLAND 2835 LHARLS OR40B. LimoTHY 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition APRIL 0 = Pages 5 Burial 2 Cremation 3 Removal from State permit. Page Department of important: If any injury or once. purposus BULAIR 19RY LAND BiRI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

EVANS FUNCTION

3 NEW ONT ONLY FOREST P.A. - BLLANG P.A. LIL MARYLAND A1050 atto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** FROM BIRTH congenital Heart disease /Medical Due to (or as a consequence of): **Examiner** FROM BIRTH TRISOMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-transit Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? o Month Dav Year 5 Other (specify) by the a 9 Unknown 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 | Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 🗌 Inpatient 5 Residence 6 □Other (Specify) 2 2 ER/Outpatient 3□ DOA his 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 5 Pending within 24 hours are: control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or 29a. Certifier 🗽 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

APR 0 4 2006

NANCY HUTTON 31. Date filed (Month, Day, Year)

ey Litten MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

mD

JOHNS HOPKINS HOSPITAL GOONORTH WOLFE STREET, BALTIMORE, MD Registrar's Signature 32

**ORIGINAL** 

D31002

3,2006

		,	1 - For State Registrar		of Man	yland /	•	artmen			and M		Reg. No.	6	10340	
4:	Physici	an	Decedent's Name (First, Middle, Margaret	Last)	Lu-	t 7						2. Date of Dea Month April	1 , Day 200	6 Year	3. Time of Death	
	/Medic	500	4a. Facility Name (If not institution,	give street and		UZ.		4b. City,	Town, or	Location of	of Death	7,0111	4c. Count			-
	Examili	eı.	Genesis-Cromwe	-				Ва	ltim	ore			Ва	alti	more	
	Funeral Director		578-34-3864	6. Sex 1 ☐ M 2 🔀 I		n yrs. last b 78	irthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth NOV . 9	1927		hplace (State or Foreign unity) Shington, DC	
	Maryland -f show lind at	tor	Usual Residence of Decedent  10a. State 10b. County  MD C	erroll	16	Dc. City, Tov		ksbur	g						10d. Inside City Limits 1 ☐ Yes 2 No	_
	with the	Funeral Director	10e. Street and Number 1537 Deer Park	Rd.				10f. Zip	Code 1048				10g. Citizen of		ountry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show apply injury or other traumatic event, the Mardical Exemination and the popular and the modified at once.	by	11. Marital Status  1 Never Married 2 Marri 3 X Widowed 4 Divorced	Armed 1 ☐ Ye If Yes,	Decedent Eve I Forces? es 2X No Give or Dates:	er in U.S.		Was Deced If Yes, spec	offy Cuba	spanic Ori n, Mexicar Specify:	i, Puerto	ecify Yes or No- Rican, etc.)		ck, Whit	ncan Indian, e, etc. hite	
Maryland 21215-0036	l within 72 ho iene. r then "netur the Maxical I	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12	grade complete	ed) e (1-4or 5+)	16	(Give life.	dent's Usua kind of wo DO NOT us OMEMA	rk done d se retired	ation during mos )	t of work	ing	16b. Kind of E	ar un		
land	should be filed and Mental Hyg s marked othe umatic event,	To Be C	17. Father's Name (First, Middle, L William	ast)	Gribb:	le		~ -		_	gnes	e (First, Middle,	_	me) digo		
	and 2 should baith and No. 27 is maner trauma		19a. Informant's Name/Relationsh		son	19		•	,			a <i>l Route Numbe</i> inksbur		21 D		
Baltimore,	Pages 1 and of the control of the co		20a. Method of Disposition  1				ery, crei	nsition (Nari matory or o	ther plac		4/6,	Date / 06	20c. Location Suit			
Balti	permit. Pages 1 Department of H Important: If Ite any injury or of once.		21. Signature of Funeral Service I	ie see Wil	lliam (	G. Dau						ck Towso	n Fune: 21204	ral	Home, Inc.	
1,092	Physician //Medical Examiner  the privipal-fransit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	at caused thrope each line.  Official for as a control (or a) (or	onsequence	e of):	er the mod	e or dyini	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Li 4 □ Pi	outcome of ve birth 2 [ regnant at tirn nknown	Fetal deat		Ectopic pr						ate of de	livery Day Year	
Ω.	es pe	þ	Part II. Other significant condition  Demenfi	ns contributing	o death but r	not resulting	in the u	inderlying c	ause give	en in Part I	l.				o the cause of death?	
Division of Vital Records,		Completed												Were an prior to death?	utopsy findings available completion of cause of 2 No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					Othe			th (Check only o				_
on of	fter	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig		☐ Inpatient ate of Injury Month, Day Y		. Time o Injury		8c. Injun Worl	4 (3.2) (4)		ome 5 ☐ Resid 28d. Describe h			ciry)	_
Divisi	al or Attending tatter death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could r 4 Homicide determ	01 10	lace of Injury uilding, etc. (	- At home, (Specify)	farm, st	reet, factor	y, office			28f. Location (5 City or Tox		nber or R	ural Route Number,	_
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier 1 Certifyin (Check only one)	-vaminar. On the	a hacie of a	comination s	and/or in	noiteniteave	in my or	ninion des	th occur	and due to the red at the time,	date and place	and du	to the cause(s)	Ī
)	To the Youthing To the comp	Me	29b. Signature and title of certifier	n GA	m	כנים		290	. Licenso	number	755		29d. Date sign	d (Mon	2006 2015 9	
	5		30. Name and address of person  Oinglin GAE	who completed	cause of dea	th (Item 23a	(Type	Print) Ra	ver	n Bl	vol	Bash	none,	m	12/259	
***	Sta Regist		31. Date filed Month Day, Year) APR 0 4	2006	Z. Registrar's	Signature	A COL	de								

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			1 - For State Registrar	•	Certificate of Death	Reg. No	THOU DUU
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medio		Roberta Isa	acs Matheu	)5	Month Da	2006 0449 M
	Examin		4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Death		County of Death
				5 prital 7. Age (In yrs. last birth	Bethesda  If Under 1 Year If Under 24 Hrs.		contgomery
	Funeral Director		5. Social Security Number 6. Sex 10		rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)  Y  Thdiana
	· ·		Usual Residence of Decedent			70 70 170	
	arylar show	_	10a. State 10b. County	10c. City, Town	1 20		10d. Inside City Limits 1 Yes 2 □ No
	the M	ecto	10e. Street and Number	Marzh	179 ton, DIC.	10g Cit	tizen of Whal Country?
	Sa or	Funeral Director	570026thSt, NU	V	20015		SA
	deeth ma 2;	nera		12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian,
9	after or Its	J.	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1 Pes 2 No Specify:	rican, etc./	Specify: 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
8	urs!',	d by	3 Widowed 4 Divorced	Year or Dates:		155 /	willte
7	in 72 in mat	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ring	(ind of Business/Industry
212	d with giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5+) Le	gal Indexer	Lego	al Publication Firm
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yla	should be nd Mental marked o	2		Isaacs	Doroth		
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylar nt of Health and Mental Hygiene. If item 27 is marked other than "naturs!, or Itema 23a or 28a-f show or other trsumatic event, it a Mudical Examiner must be cultified at		19a. Informant's Name/Relationship (Ty) John Paul Mathe		Mailing Address (Street and Number or Rui		wYork 10024
	Heall tsm 2		20a. Method of Disposition	20b. Place of	Disposition (Name of		ocation - City or Town, State
OE	Pages nent of ont: If it ory or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	iemoval from State	r. crematory or other place) Peake Crematory 3-3	1-06 Bel	tsville, MD
Baltimore,	permit. Pages Department of I Importent: If its any Injury or o		21. Signature of Funeral Service License		22. Name and Address of Facility Fou	PP Funeral	Cremation Service
<u>-</u>	80 = 50			mo1358			191 MD 20910
			shock, or heart failure. List only or	ications that caused the death. Do not be cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of			
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68760,	physics the t			<b>1</b>			
Box (	nding use a	J/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	T-04		23d. Date of delivery
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ØNo	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.O.	res thet the death certifical igned by the attending phy be detached for use as th	Phys	9 Unknown			an Database	
	The law requires thet the death certifica ite hes been signed by the attending phoage 2 should be detached for use as it	Completed by Physician/Med	Part II. Other significant conditions cor	holus	The underlying cause given in Part I.		use contribute to the cause of death?
Ö	w require been sig should b	eted	D	POIN		24a. Was an	24b. Were autopsy findings available
Vital Records,	he lav e hes ige 2	dmo	Preymoria	Iland inter		autopsy performed?	prior to completion of cause of death?
ta	en: T tificat tor, pa	0	25. Was case referred to medical	bleed, intra	Cranial bleed 26. Place of Deal	1 ☐ Yes 2 ☒ No th (Check only one)	1 ☐ Yes 2 ☐ No
	nysici nis cer direc	To B	examiner? 1 Yes 2 No	fospital: 1 Nnpatient 2 ER/Out	Othor	ome 5 Residence	6 □Other (Specify)
0 4	ng Pt Viter ti uneral		27. Manner of Death 1 □Natural 5 □ Pending	28a. Oate of Injury 28b. T	ijury Work? /	28d. Describe how inju	1. /
Sio	Attending Physician: r death. ector: After this certific by the funeral director,	icati	Accident investigation  3 Suicide 6 Could not be	Man, 4, 2006 5. 28e. Place of Injury - At home, far	OG P, M 1 Yes 2 No	28t Location (Street a	MICLE ACCIDENT  nd Nymber or Rural Route Nymbera
Division of	effer Direct	Certification;	4 Homicide determined	building, elc. (Specify)	iii, street, raciory, oince	City or Town State	Connecticut Ave
	Hospitel or 24 hours efte Funerel Dir tely filled in I		29a. Certifier 1 Cartifying Phys	sician: To the best of my knowledge	death occurred at the time, date and place,	and due to the cause(s	and manner as stated.
	To the Hospitel or Attending Physicien: The lav within 24 hours effer death. To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2	Medicai	one)	ner: On the basis of examination and and manner stated.	d/or investigation, in my opinion, death occur		
	with To	2	29b. Signature and title of certifier	willo Man 4	29c. License number	29d. Da	ate signed (Month, Day, Year)
	· or		30. Name and address of parameter	ampleted cause of death from 22-15	Type Print)	i iiiii	011 00 1000
7	207		30 Name and address of person who co	Nay, 1119 Rocks	ille Pike, G-100.	Rockville	MD 20852
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature		, , , , , , , , ,	
	Regist	rar	APROAS	onne de de	Legal D		

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 1, <sup>Day</sup> 2006 Year **Physician** 17:52 PM Martino Josephine /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore DUndalk 94 Dundalk Avenue If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year January 18, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8, 1917 Maryland Months Days Hours 1 ☐ M 2 🗶 F 89 Director 213-03-6341 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow ury or other traumatic event, the Medical Expriner matter from the fortified at 1 ☐ Yes 2 No Maryland Baltimore Dundalk Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 94 Dundalk Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ρ Specify: White 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own HOme 8 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Marion Cascio Josephine Russo 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7925 Tralee Court, Laurel, Maryland Laraine Gregor Daughter Aprilate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2006 Baltimore City, MD. 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Little only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Physician colon cancer ~ 2.5 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The taw requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown orecic 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 2 No 1 ☐ Yes 2 ☐ No 1 Tyes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ZMZ 00058893 April 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 401 worth Breadway Cancor Conter Hene S. Browner Johns Hopkins UND Baltimore, MD 21231 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2006 Registrar

Please Type or Print in	Black Indelible Ink.	<b>Ensure All Copies A</b>	re Legible.
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			For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H tificate of L			ene 0 0 6	10343
	Physici		1. Decedent's Name (First, Middle, Pushpalata	. Last) Indravadan	n Mehta			2. Date of Death Month March	28 2006	3. Time of Death <b>7:38</b> A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	
			Sinai Hospital	of Baltimor	e	Balti	more		n/a	
inger.	Funeral Director		219-29-0332	6. Sex 7. As 1 ☐ M 2 1 F	ge (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months . Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb 24,	9. 8ii 1922 I	rthplace (State or Foreign ountry) ndia
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	death with the Maryland ma 23a or 28a-f ehow rmust be nutified at	tor	Maryland Monte	gomery	Gai	thersburg				1 XYes 2 □ No
	or 28s	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	23a	la	831 Diamond Dri			208			United	States
		Funeral	11. Marital Status	12. Was Decedent Armed Forces?		Was Decedent of Hi f Yes, specify Cubai	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
36	hours after death with the Marylan Jural', or Itama 23a or 28a-f ehow at Examirer must be notified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 271 If Yes, Give Year or Dates:	No .	1 ☐ Yes 2 【XNo	Specify:		Specify: As	sian-Indian
Maryland 21215-0036	n 72 hours "natural", edical Exc		15. Decedent' (Specify only highest	's Education	16a. Deced	ient's Usual Occupa	ation	vina	6b. Kind of Business	
21	_ 39	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) /ife. (	DO NOT use retired,	)	Wing		
121	be filed withir tal Hygiene. d other than event, tre Mi	S	17. Father's Name (First, Middle, L	5+	]	Homemaker		e (First, Middle, N	Own Hom	ne
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ΙŽ	2 should be and Mental is marked of reumatic ev	2	Ramanlal M.  19a. Informant's Name/Relationsh			g Address (Street a			City or Town, State,	
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Jagatkumar Indra	avadan Mehta	a/son 831	Diamond D	rive Ga	ithersbu	rg, Maryla	nd 20878
re,	os 1 and 2 of Health If item 27 I		20a. Method of Disposition		20b. Place of Dispo		1		20c. Location - City or	
Ē	Pages nent of ant: If it ary or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		West Arun	•	1	0/2006	Odenton,	Maryland
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service L	iconsee Thomas	De	Name and Addres	Funeral	Home & Ci	rematory, on, Maryla	P.A.
*jo	K.		23a. Part Enter the disease, or o shock, or heart failure. List of	complications that cause	d the death. Do not ent-	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		Failure					Onset and Death  5 YEARS
43	/Medical Examiner		resulting in death)		a consequence of):					
		0	Secuentially list conditions if any leading to immediate	D	tes Mellit	MZ				10 years
16	of ansit	Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
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68760,	ificate be exec g physicien an as the burial-tr	edical		d						
	ig p		IF FEMALE:							
Вох	atte for	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal death 3	Ectopic pregnancy			23d. Date of de Month	Day Year
o.	0 0	ysic	1 □ Yes 2 🛣 No 9 □ Unknown	9 Unknown	t time or death 5 E	Other (specify)				
0	tha de	y Pt	Part II. Other significant condition	-				23e. Did tob	acco use contribute t	to the cause of death?
rds	w requires been sign should be	ed b	coronary Artery	Disease, co	ngestive H	eart Fa	ilure	1 □ Ye	s 252No 3∏P	robably 4 Unknown
of Vital Records,	aw 2 si	Completed by		•	<u> </u>			24a. Was an	24b. Were a	utopsy findings available completion of cause of
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/ita	Physician: Th this certificate ral director, paç	Be (	25. Was case referred to medical examiner?					th (Check only one		
) t	Physi this o	2	1 ☐ Yes 2 ☑ No	Hospital:			4 Linuising in		nce 6 Other (Spe	ecify)
	ng fter ne	ion	27. Manne of Death  1 Natural 5 Pending		ury 28b. Time of Injury	Work	rat ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	Attending r death. ector: After by the fune	ficat	2 Accident Investiga 3 Suicide 6 Could n	ot be	jury - At home, farm, stre		163 2 110	28f. Location (Str	eet and Number or F	lural Route Number.
D	al or /	Certification:	4  Homicide determin	building, e	tc. (Specify)	,		City or Town	, State)	
	To the Hospital or Attendinwithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying (Check only one) 1 Medical E	g Physicien: To the best examiner: On the basis of and manner st	of examination and/or inv	n occurred at the time restigation, in my op	ie, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	0 (	PID	29c. License			d. Date signed (Mon	
			· Giller My	many		RES-	-000	N	narch 28,	2006
	Ki		30. Name and address of person v		death (Item 23a) (Type,	Print)	.4. 5	240		lvedere Ave
	10		Eiken Zingr			Hospital	or Baltin	nove Bal	Ltimore, M	aryland21215
-	- Sta Registr		31. Date filed (Month, Day, Year)		rar's Signature	K)				

			ricase i			artment of Health and M		-	
			1 - For State Registrar	olalo ol marylana		tificate of Death		g. No. 006	0344
			Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	Physici		Jane Louise	Manious			Month April	Day Year 1. 2006	6:05P M
)	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or Location of Death	Претт	4c. County of Death	
	LXann		FutureCare Cheri	ywood		Reisterstown		Ba1	timore
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. last i	birthday)	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day,		pplace (State or Foreign untry)
	Director		215-14-2/43	IM 2₫F 83	Yrs.	World Days Flours Will.	Aug. 26,	1922 Ma	ryland
	D		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	we or Lo	cation			10d. Inside City Limits
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	78a-f	Director	MD Baltin  10e. Street and Number	nore	<u>.</u>	Reisterstown 10f. Zip Code	10	g. Citizen of What Co	into/2
	with with	늅		. 1			10		
	death with the Maryland ms 23a or 28a-f ehow r must be notified at	Funerai	1000 Dunholme Roa	12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	USA 14. Race - Ame	
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ร	urs a	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No <i>Specify:</i>		Specify: Whi	te
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N	filed wi Hygien ther th	ပ္ပြ	11		Seli	Employed-Owner		ar & Resta	urant
	8 H a 9	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		aiden Sumame)	
<u> </u>		မ	Claude Deeds	_		Ella B			
Jar	2 sh and ie m		19a. Informant's Name/Relationship (Ty	pe, Print) 1:	9b. Maili	ng Address (Street and Number or Rura	al Route Number,	City or Town, State, 2	ip Code)
e, e	ges 1 and 2 should t of Health and Mer i if item 27 ie marke or other traumatic			)aughter		Dunholme Road, R		OWn MD 2  Oc. Location - City or	
	Pages 1 nent of H int: if ite iry or ot		20a. Method of Disposition 1	emoval from State	tery, crei	sition (Name of natory or other place)	2	oc. Location - City of	TOWN, State
	t. Pa tmen tant:		4 Donation 5 Other (Specify)	A.	7	en Cemetery 4/5/0		Hagerstown	
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	40 = 4 d		cepton	In January		Eline Funeral Home		erstown, M	D 21136 Approximate
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δ	death certificate e attending phys d for use as the	Physician/Medi							
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VItal	sician: T certificat rector, pa	Be (	25. Was case referred to medical examiner?			26. Place of Deat	h (Check only one	1	
<u>&gt;</u>	Physicia this cer al direct	2	1 Tes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatier		me 5 Resider	nce 6 Other (Spec	city)
ō ⊏	ding Ph h. After th funeral	ë	27. Mann of of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28t (Month, Day Year)	o. Time o Injury	Work?	28d. Describe how	w injury occurred	
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Ë	or Attending Physician: after death. Director: After this certific in by the funeral director.	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, st	reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru State)	rai Route Number,
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	To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Att completely filled in by the fun	edicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	rer: On the basis of examination and manner stated.	age, deat and/or in	h occurred at the time, date and place, vestigation, in my opinion, death occuri	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
	ithin 2 the mple	Med	29b. Signature and title of certifie	Stated.		29c. License number	29	d. Date signed (Monti	n, Dey, Year)
	F ≥ F 8			Rin		721566		16/3/A/	
,	L.		30. Name and address of person who co	ontoleled cause of death (Item 22)	a) (Type	Print		7/1/00	
	M		So. Ivaline and address of person who de	1012+ch 10 - 2- 41	~, (1 <b>y</b> p <del>0</del> ,	1838 Green	re Tr	11 71	200
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			. For	State of M							ental Hyg		100	1001.5
			For Stata Registrar			Cei	tificate	of E	Death			eg. No.	100	10040
	Physici	an	Decedent's Name (First, Middle, La								2. Date of Dea: Month	Day	Year	3. Time of Death
1	/Medic		LILLIAN R.								March		2006	4: 10 PM
	Examin	er	4a. Facility Name (If not institution, giv				4b. City, To		Location o sing			4c. C	county of Deat	
	C		Calvert Manor 5. Social Security Number 6.5		Ge (In yrs. I		If Under 1		If Under 2		8 Date of Birth			nplace (State or Foreign untry)
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	ס		Usual Residence of Decedent								reicai jo	1715		
	arylar show	_	10a. State 10b. County  MD Cec:	i ]	10c. City	, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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	a or 2	Dİ	10e. Street and Number	r Dood			10f. Zip 0	 2191	0		'	_	en of What Co USA	unity?
	ns 23	Funeral	126 Mount Zoa	12. Was Deceder	it Ever in U.S	S. 13.				gin? (Spec	cify Yes or No- Rican, etc.)		I. Race - Ame	rican Indian,
ယ	or Iter	필	1 Never Married 2 Married	Armed Forces 1 ☐ Yes 25 If Yes, Give	3?	1	_			, Puerto F	Rican, etc.)		Black, White	
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5-0	natu	etec	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa done di	tion uring most	t of workin	ng	16b. Kind	d of Business/	ndustry
21215-0036	within 72 hours after death with the Maryland ene. then 'natural', or items 23a or 28a-f ahow the Medical Exercites nast ke natified at	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)		usewi					At .	Home	
	filed Hygi other ent, t	BeCc	17. Father's Name (First, Middle, Last	)					18. Mothe	r's Name	(First, Middle, I	Maiden S	umame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinet must be notified at any injury or other treumatic event, the Medical Examinet must be notified at any injury.	To B	Fredrick H	. Robins	on				Rose	ella	Heil			
lary	sho and h		19a. Informant's Name/Relationship (	Турө, Print)		19b. Mailin	ng Address (	Street a	nd Numbe	or or Rurai	Route Number	City or	Town, State, Z	lip Code)
	and sealth m 27		Bettylou M. Br	own-Daug					oar 1					
ore	ges 1 t of H if Ite or oth		20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from Stat	9 Par	lace of Dispo metery creat KWOCO O	sition (Name natory or oth	er place	<sub>)</sub>				ation - City or ville	Maryland
Baltimore,	nt. Partmen		`4 ☐Donation 5 ☐ Other (Special				_		1					
Bal	Depermine Depermine Important or any in procession or any individual or any indin		21. Signature of Funeral Service Lice	ME 4 -1	1.		Name and			EVA	NS CHA d-Park	PEL	OF MI	EMORIES
	_		23a. Part1. Enter the disease, or com	plications that caus	ed the death								re, MD	Approximate
ı	Commission		shock, or heart failure. List only Immediate Cause (Final	100	4									Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		eviti									3.5 years
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Вох	death certificat e attending phy d for use as th	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Tetania ara					23	3d. Date of del	very
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Records,	0 <u>c</u> 0	Completed	Anemy								24a. Was a autops perfori	V	prior to death?	topsy findings available completion of cause of
a		e Co	25. Was case referred to medical						OC Place	of Dooth	1 Yes		1 🗆 Yes	2 No
Ē	Physicien: r this certificatal director.	o B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpa	tient 2 🗆	ER/Outpatier	nt 3□ DOA	Othe			(Check only on ne 5 ☐ Reside		Other (Spec	cifv)
וסר		n: T	27. Manner of Death	28a. Date of In (Month, D		28b. Time o		c. Injury Work	Berthell B. W.		8d. Describe ho			,
Sior	Attending or death. ector: After by the fune	atlc	2 Accident investigation	n		,,	М		′es 2 🗆 l	No				
Division of Vital	after death after death Director:	Certification:	3 Suicide 6 Could not be determined	288. Place of 1	njury - At ho etc. <i>(Specif</i> y	me, farm, sti	eet, factory,	office		2	l8f. Location (Si City or Town		Number or Ru	iral Route Number,
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	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa one)	hysician: To the bes miner: On the basis and manner:	of examinat	ion and/or in	vestigation, i	n my op	e, date an inion, dea	d piace, a th occurre	nd due to the c ed at the time, d	ause(s) a ate and p	nd manner as place, and due	to the cause(s)
	To the	Me	29b. Signature and title of certifier				29c.	License	number				signed (Monti	
	. , , , ,		Solerelm	w MD				206	443	13		04	103/2	006
	5		30. Name ddress of person who	completed cause of	death (Item	23a) (Type,	Print)		, 1	0	ing S			
	J		Dr Weidne	r 188	110	elea	rapt	)	ra.	KIS	ing S	un	mo	21911
	Sta Registi		31. Date filed (Month, Ddy, Year)  APR 0 4 20	32 Regis	strar's Signal	enur	/					/		
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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MARCH Day **Physician** 2006 4:00 PM lian /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 100 M 2□ F 030 16 5333 Usual Residence of Decedent Director north Largolina 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f ehow other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Messer BALTINORE LARENEY 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code AGT ö 0 or iteme 23a 21234 SEHTLAGI OGES BLVO. #2215 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after 1 Yes 25 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced "nature!". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry HARFORD LOUNTY permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene important: If item 27 ie marked other then eny injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) Rincipal 64R5-25YE1 BOARD OF LOUGATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (ZARZ AUHZOL 3122 (1) 1002 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 BLVO ACT.#2315 Lacry (\*)
Date 20c. Location - City or Town, State · W 202132 12ABS SESO DALTHE APRIL 5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Air En Garons BULAIR ( JARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ( 22. Name and Address of Facility 21. Signature of Funeral Service License - BELRIR, P.A DDC 22. Name and Address of Facility
ELANS FUNERAL CHAREL — GEL
3 NEW PORT ORIVE FOREST HILL XOX MERYPERO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Box 68760 pe Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. I page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. <u>م</u> 3 Probably 4 Unknown PULMONARY HYPERTENSION 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DIABETES MELLITUS TYPE II has autopsy performed? 1 Yes 2 200 No this certificate 1 Yes or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 | Pending Injury death. М 1 □ Yes 2 □ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of pertifier, 29c. License number 29d. Date signed (Month, Dey, Year) mallia m. O 30 200 D 41410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOGINDER P M.D. 7601 OSLER DRIVE TOWSON, MARYLAND 21204 MEHTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 2006 **Physician** 1, G. 9:15AM <sup>™</sup> McCormick /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare- Hamilton N/A Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. July 5, 1911 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M A F 212-09-2625 94 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 10b. County 1 ☐ Yes 2 ☑ No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code rmen of Health and Menial Hygiene. rtant: If item 27 is marked other than "natural", or Itema 23a or ijury or other traumatic event, Ina Musical Examplar tra 21234 3402 Lambros Road U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crown Cork & Seal Machine Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Simms Charles Geiger Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Lambros Road Baltimore, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) James McCormick-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Department Important: If any injury or once. 4/5/06 Parkwood Cemetery Baltimore, Maryland Heather Cain Leonard J. Ruck, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 Leather 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMPNIA /Medical Due to (or as a consequence of): Examiner BRONCHUS INTERMEDIUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit or Attending Physicien: The law requires that the death certificate be executed TUMOR Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year Month 4□Pregnant at time of death 5 Other (specify) ed by the a Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown PERTENSION 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an MENTIA autopsy performed? 1 🗌 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how intury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title d 30. Name and address 1 ps on who completed cause of death (Item 23a) (Type, Print) MW NAIN 00, 00 APRIL 03 HUSPIT AZ BATIMOLE SAMARITAN 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 0 4 2006

State of Maryland / Department of Health and Mental Hygiene 0348 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** April 2006 1. 1:15 AM Doris Ellen Mitchell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Mercy Ridge Assisted Living Timonium If Under 1 Year If Under 24 Hrs. North, Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 7, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 👿 F North Carolina Director 239-07-9632 86 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h County itam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examination must be notified at 1 ☐ Yes 2 X No Director Maryland Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 21093 U.S.A. 2525 Pot Spring Road by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 2 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Dixie Anna Swindell Thomas Otis Bundy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 839 Iron Rail Court Woodbine, Maryland 21797 Stephen Mitchell Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 4 Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4-4-2006 Towson Maryland 21. ig atus Funcial Fel ice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final Physician ongestive Week disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown certificate has been signed firector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 22 No 24a Wasan autopsy performed? Yes 22No 1 Yes : After this certification afuneral director, Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) TEO IIVING examiner' Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deati To the Funeral Director: 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI 2006 nestine 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Valley Road MD 21092 Dulane Wence 2 I IM MIUM 605 Ernestine 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		ľ	For State Registrar		State of	Marylan		artmen rtificate				lental Hy	giene Reg. No.	6	0349
	Physici	20	1. Decedent's Name (First, Mid-				_					2. Date of Dea Month	ath Day	Year	3. Time of Death
No.	/Medic		Don	Ε.		ietta,	Jr.					March	30, 200		4:13 A M
	Examin	er	4a. Facility Name (If not instituti			•		4b. City,	Town, or	Location of	of Death		4c. County	of Death	
			Greater Balt: 5. Social Security Number	6. Sex		al Cent		ff Under	OWSO1	n ff Under	24 Hrs.	8. Date of Birt	h	timo:	
*	Funeral Director		422-28-8898		4 2 F	7		Months	Days	Hours	Min.	NOV. 1	1926	Ala	ptace (State or Foreign ntry) Dama
			Usual Residence of Decedent												
	nylan show	_	10a. State 10b. Coun	-		10c. City	y, Town or Lo								10d. Inside City Limits
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	eath 1	Funeral	205 East Jopp			dent Ever in U.	S 13				gin2 (Sn	ecify Ves or No.			can Indian,
	iter d	Fun	11. Marital Status  1 □ Never Married 2 □ Married		Armed Ford	ces?	10.	f Yes, spec	rfy Cubai	n, Mexicar	i, Puerto	ecify Yes or No Rican, etc.)	Blad	k, White,	
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ore	Pages 1 ar nent of Hea int: if item i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Rer	noval from S	1010	lace of Dispo	natory or o	ther place			Oate /OC	20c. Location -		
Baltimore,	tmen tant:		4 Donation 5 Other				ltop S		,	1	4/1/		Towson		
Ba	permit. Pages 'Department of I Important: if its eny injury or ot once.		21. Signature of Funeral Service	a ricensee	W1111	am G.						son, MD	21 204	at H	ome, Inc.
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complica st only one	tions that ca cause on ea	used the death ch line	n. Do not ent	er the mod	e of dying	g, such as	cardiac	or respiratory ar	rrest,		Approximate fnterval Between Onset and Death
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	/Medical Examiner		Todaling in doutin		Due to (o	as a conseq	uence of):	ar	1 00 1	181					
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V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>【</b> .	(2	27	0011	i ter		ar-	619	ame	211/4	٨	
ó	be executed icien and burial-transit	Еха	resulting in death) Last	· .	Due to	a conseq	u nce of :		1			- 1	mi		
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39 >	ing pt	Med	IF FEMALE:												,
Вох	leath certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?	230	1 Live bir	ome of pregna th 2 ☐ Feta	f death 3	Ectopic pr					23d. Dat Mo	e of deliv	ery Day Year
P.O.	the the	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregna 9☐ Unknov	int at time of down	eath 5L	Other (sp	өспу)		-				
<b>a</b> .	es that the gned by be detac	by Pr	Part If. Other significant condi	tions contri	buting to dea	ath but not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco use cont	ribute to t	the cause of death?
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Ξ	ai or A s after ii Direction by	Certification:	4 Homicide	mined	buildin	g, etc. (Specify	y)	001, 1201019	, 011100			City or Tov			
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atte completely filled in by the fune	Medical (	29a. Certifier 1 Certify (Check only one) 2 Medical	ing Physic al Examine	r: On the base	sis of examina	wledge, death tion and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) and ma date and place,	nner as s and due t	stated. o the cause(s)
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MACLETTA, DON

		-	For State Registrar	State of Ma	ryland / [	Departme Certifica			ind Mer		ene))(	5	0350
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	Funeral Director		5. Social Security Number 6. 9		(In yrs. last bil 98	Yrs. If Under	Days	Hours 1	24 Hrs. 8. Min. M	Date of Birth (Month, Day, ay UB,	Y91907	9. Birthpl Count NEW	ace (State or Foreign try.) York
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Balt	Depart Import any in		21. Signature of Funeral Service Lice	nsee		22. Name Ruc 1 U5	nd Addres K Tou U You	s of Facility ISON F	unera Lows	l Home on, Md	. Inc. 21204		
	nysician /Medical		23a. Pant . Enter the dise .e., or conshock, or heart failure. List only the timediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	the death. Do		ode of dying		cardiac or re	espiratory arre	st,		Approximate Interval Between Onset and Death
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Box	ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetel death	3 □Ectopic 5 □ Other (					23d. Dat Mor	te of delive nth	ory Day Year
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			) a me	حمن			D 58	64	6		April	3	2006
	K		30. Name and address of person wh	completed cause of d	eath (Item 23a)	(Type, Print)		80 10		i n	30, 6411.	(435)	7 7 3U
	St	ate	31. Date filed (Month, Day, Year)	32. Registra	ur's Signature	T W.	e e	1300216	A Committee A	* 10	L VIII		4 1 1 7
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 31 Michae **Physician** Month Nelson March 4:49 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkilns Baltimone Hospital Cik N/A Johns If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min B. Date of Birth DEC. 30, 1939 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2□F Director 218-36-3657 66 Yrs. Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits in then "naturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be restilled at Director BALTIMORE 1 ☐ Yes 2 X No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 323 WILLOW OAK CIRCLE 21208 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) OWNER JANITORIAL SUPPLIES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Peges 1 end 2 should be fil iment of Health and Mental H lant: If tem 27 is marked of NELSON FLORENCE WEINER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2 s Depertment of Health ar Important: If Item 27 is eny injury or other treu QDCs. BETTY NELSON / WIFE 323 WILLOW OAK CIRCLE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TIFERETH ISRAEL CEM. 04/03/2006 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stenosis Physician Aortic years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine led by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Olvision of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cete has been signification of the center of 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐ Yes 2 X No 1 Yes Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide To the Hospitel o within 24 hours eft To the Funerel DI completely filled in 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) M.D. RES-000 and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe Street, Bullimore, Manyland Enc J Hanh MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

APR 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician Month P. M 2006 HELEN 1ARTH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** FRANKLIO BALTIMOR 2000 W 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Davs 1 □ M 2 1 F Director 71d 18 8873 1ARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location "naturel", or Items 23a or 28a-1 show 10d. Inside City Limits the Modical Examiner rount be notified at 1 ☐ Yes 2 No Directo HARFORD 029/18DE FALLITON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2104 1802 LAMONT .64 7500CT 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 250 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nit. Pages 1 and 2 should be filed within artment of Health and Mental Hygiene. ortant: If item 27 is marked other then injury or other treumatic event, Its M. Elementary/Secondary (0-12) College (1-4or 5+) 127 85 STRETARY MADIZZAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SAPPINGTON ဂ MAILLIC HARRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 JUNTHIA SONORA LOURT 20b. Place of Disposition (Name of cemetery, crematory or other place) APRIL 3 20a. Method of Disposition 20c. Location - City o Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 3000 FOREST HILL / IERAPHUO 21. A material of Funeral Cervice License 22. Name and Address of Facility

EVAN FUNEZAL HARL — DELE

3 NEWPORT ORIVE FORESTHILL M -BELAIR YOU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the burial-tran and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 110 To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Yes 2 ☐ 1 € 1 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Tes 2 🗌 No hours after death. 2 Accident Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number

State

State Registrar Tom

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,9105

32. Registrar's Signature

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Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1   Yes   2   No   3   Probably   4   Michigan					e or Print in Blac			-	_	W 400 / N
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Physician // Medical Examiner: Examiner Examiner				23a. Part1. Enter the disea +, or complicat shock, or heart failure. List only one	ons hat caus dit e death. Do	not enter the mode of dyi	ng, such as cardiac or	respiratory arrest,		Interval Between
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	0 - 0		27. Manner of Death	28a. Date of Injury 28b. (Month, Day Year)	Time of 28c. Injury Wo	ry at 25 ork?	3d. Describe how	injury occurred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	0	endir sath. or: Af he fu	atlc	2 Accident investigation						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Ž	r Atter de l'recte	ij	determined	<ol> <li>Place of Injury - At home, building, etc. (Specify)</li> </ol>	farm, street, factory, office	21			turai Houte Number,
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		Hosp 4 hot Fune ely fil	ica	(Check only 2 Medical Examinal	: On the basis of examination a	ge, death occurred at the land/or investigation, in my	ime, date and place, at opinion, death occurre	d at the time, date	and place, and du	e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		thin 2 thin 2 the mplet	Med		and manner stated.	29c. Licer	se number	29d.	Date signed (Mon	th, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		To Too			21164					
State  JIANYI ZHANG, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD 21902  31. Date filed (Month, Day, Year)  32. Registrar's Signature		N			211	VAOL	)T028T50T	AP	KIL 2, 20	JUO
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		104					SVSTEM DED	RY POTNIT	MD 2190	2.
State		C.	ata		32. Registrar's Signature	TAUTH CARE		CA LOTHE	, 2250.	
				APR 0 4 2006	Roseins D. A.	perse				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month RHUNDA 12:30 PM POWELL March 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HARBOR HOS PITAL 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 1 ☐ M 2 💢 F 218 48 0658 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: if item 27 is marked other than "natural", or tems 23a or 28a-f show ary or other traumatic event, the Modical Examinar must be notified at 10a, State 10b. County 10d. Inside City Limits MD 1 Yes 2 No altimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 📉 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be aymond 2 19a. Informant' Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 815 Bethune Rd. Apt.A3 Iraci 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or Mt. Zion Cemetery April 4,2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Sames E.
LOS W. Nort 21. Signature of Funeral Service Licenincoln Funeral Home P.A. Ave. Balto. MD 212011 W. North Ave. 3a. Part. Enter the diseas: or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS 9 day /Medical Due to (or as a consequence of): Examiner SCHEMIC BOWELS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the ettending physiclen and dbe detached for use es the burial-transit RESPIRATORY FAILURE Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical DM IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? the funeral director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xinpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Matural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined within 24 hours efter de To the Funeral Directo completely filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) morebston RES 001 March 29, 2006

Registrar
DHMH 17 Rev 1/2001

State

BOR

HOSPITAL, 3001 HANOVER

CT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR

32 Registrar's Signature

GEBSKA

MILENA

31. Date filed (Month, Day, Year)

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		1 - For State Registrar	State of Maryl		artment of F tificate of		d Mental Hy	/giene	06	10355
Physicia /Medic		Decedent's Name (First, Middle, Last,     MARTHA SYMINGT(		N			2. Date of Do Month	Day	Zoo6	3. Time of Death
Examin		4a. Facility Name (If not institution, give 12427 PARK HEIC	HTS AVE		4b. City, Town, o	MILLS		BALT	nty of Death	
Funeral Director		5. Social Security Number 6. Sec. 216-28-6780	7. Age (In)	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H		7 1910	9. Birth	place (State or Foreign ntry) INOIS
Maryland -f show	tor	10a. State 10b. County  MD BALTIMO		. City, Town or Lo	cation	5				10d. Inside City Limits 1 ☐ Yes 2 No
death with the Maryland ms 23a or 28a-1 show	ral Director	10e. Street and Number 12427 PARK HEIO			10f. Zip Code	1117		10g. Citizen d		ntry?
	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 2 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)		ace - Ameri lack, White,	
within 72 hours after ene. then "naturel", or ite	Completed	15. Decedent's Edu (Specify only highest grad	cation	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of v	vorking	16b. Kind of		
77 77 18 18 18 18 18	Be	1 2 Y R S  17. Father's Name (First, Middle, Last)		HOUSE	EWIFE		lame (First, Middle	, Maiden Sum	MAKE ame)	R
s 1 end 2 should be filed I Health and Mental Hyg Itsm 27 is marked othe other traumatic svent,	2	DONALD L. SYMIN  19a. Informant's Name/Relationship (Ty HENRY H. JENKIN	pe, Print)		ng Address (Street	and Number or		oer, City or Tow		O Code) MILLS 2 1117
permit. Pages 1 end 2 Department of Health a Important: if itsm 27 is sny injury or other trai	,	20a. Method of Disposition  1 Ma Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	lemoval from State	b. Place of Dispo cemetery, cren		ce)	Date / 08/200	20c. Locatio	n - City or T	own, State
permit. Departmitimportal		21. Signature of Funeral Service Licens	und	22 H I	Name and Address ENRY W. 5924 YOF	ss of Facility JENKII	NS & SO	NS CO.		
Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the cause on each line.  He was a Due to (or as a con	MONIA						Approximate Interval Between Onset and Death
ficate be executed physicien and is the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con							
= 00.61	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy				Date of deliver	ery Day Year
es the	<u>۾</u>	Part II. Other significant conditions cor	ntributing to death but not	resulting in the un	nderlying cause give	en in Part I.		tobacco use co	ontribute to t	he cause of death?
: The law r cete has be ; page 2 sh	Completed			,					o. Were auto prior to co death? 1 \( \subseteq \text{Yes}	psy findings available mpletion of cause of
yelclan: The is certificete director, pag	To Be	25. Was case referred to medical examiner?	lospital:	2 ☐ ER/Outpatien	Oth		eath (Check only Home 5 Res		that (Canal	
Attending Physician: The law r death. ector: Alter this certificate has by the funeral director, page 2 s		27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea.	28b. Time of	28c. Injun Work			how injury occ		у)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	ecify)			City or To	wn, State)		al Route Number,
To the Hoep within 24 hou To the Fune completely fi	Medical	one)	sician: To the best of my ner: On the basis of exan and manner stated.	knowledge, death nination and/or inv	estigation, in my o	pinion, death oc	ice, and due to the curred at the time	date and place	e, and due to	the cause(s)
T W TO		. Specific -	eeuus		29c. License		Bathr	29d. Datersign		
90'		30. Name and address of person who co		Item 23a) (Type, 6301 N		ES ST.	Balter	was M	0 2	212
Sta Registr		31. Date filed (Month, Day, Year) APR 0 4 200	32 Registrar's S	ignature	MES					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Pauline M. Payne 12:20 AM 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/AUnion Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 231-40-7351 1 □ M 78 Director March 29,1928 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or iteme 23a or 28a-f show enty injury or other traumatic event. The Mudical Examinat must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3315 Chestnut Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②XXNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify 2 White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Seton High School 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene E. Bryant Estelle Woodv ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allan J. Payne 3315 Chestnut Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of Date 20c. Location · City or Town, State 20a. Method of Disposition cemetery, crematory or other place, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans' 4/6/2006 Garrison Forest, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatus of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, INc 3631 Falls Road, Baltimore, Maryland Funeral Home, INc. 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Sep SIS days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The lew requires that the death certificate be executed Due to (or as a consequence of): attending physicien a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed page certificate 2 1 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 10 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death.
I Director: Aft
of in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) AT2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			1 - State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of			ene 0 0 6	10357
			1. Decedent's Name (First, Middle, La	st)				2. Date of Death		3. Time of Death
	Physici /Medic		Dorothy I. Pitt					Anril	Day Yea	14:35 M
}	Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Death		4c. County of De	ath
			118 Old Church			Jop			Harfor	d
	Funeral Director		210-14-74/5	□M 2□F	9 (In yrs. last birthday, Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, )  June 12	(ear) 9. 8 1923	irthplace (State or Foreign Country) MD
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl f sho	ō	MD Harford		Joppa	3				1 ☐ Yes 2 ☑ No
	28e	Funeral Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What (	Country?
	3a ou		118 Old Church	Rd.		2108	35		USA	,
	death	nera	11. Marital Status	12. Was Decedent I	Ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Ar	nerican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other treumatic event, the Medical Evantmer must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 N  If Yes, Give Year or Dates:	40	1 Yes 2 No	an, Mexican, Puerto Specity:	Hican, etc.)	Specify:	white
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215	hin 7.	Completed	(Specify only highest gra Elementary/Secondary (0-12)	de completed)  College (1-4or 5	life	kind of work done DO NOT use retired	during most of work d)	ing		,
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nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last	)			18. Mother's Nam	e (First, Middle, Ma	aiden Sumame)	Schools
<del>Z</del> a	Men Men arke	2	Richard H. J. S				Ella A. (	last nam	e unknov	vn by infor-
Maryland	2 sh and is m		19a. Informant's Name/Relationship (				and Number or Rur			, Zip Code) mani
	1 and 16alti am 27		Stephen Pitt, S  20a. Method of Disposition	on	1879 20b. Place of Disp		k Trail,		VA 20191 Dc. Location - City (	T Ci-t-
Jor	if ite		1 Burial 2 ☐ Cremation 3 ☐		cemetery, cre	matory or other plac		6- 66		
Baltimore,	it. Partimer ritmer ritent njury		*4 ☐ Donation 5 ☐ Other (Special 21. Signature 2 (up = 1 erv = 1 ferv	y) <b>Q</b>				Gardens	Timonium	, MD 21093
Ba	permii Depar impor any ir once.		Bryan W. Cla	ry		<sup>2. Name and Addre</sup> _emmon F   0 W. Pac	uneral Ho donia_Rd.	ome of D , Timoni	ulaney V um, MD	alley, Inc. 21093
П			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arres	it,	Approximate Interval Between
-	Pnysician :		Immediate Cause (Final disease or condition	. 41	A					Onset and Death
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58760,	be e sician buria	al E								
587		edical		_ d						
Box (	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of d	elivery
ň	death s atte d for	Physician/M	in the past 12 months? 1 Yes 2 Mo	1□Live birth 4□Pregnant at		□Ectopic pregnan <i>c</i> y □ Other (s <i>pecify)</i>	/		Month	Day Year
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٥,	s tha	by P	Part II. Other significant conditions	contributing to death bi	at not resulting in the u	inderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute	to the cause of death?
rd	w require been sig should b		Hypertension					100 Yes	2 □ No 3 □	Probably 4 Unknown
Records,	e law re has be ge 2 sho	Completed						24a. Was an	24b. Were	autopsy findings available completion of cause of
ž	The ate ha	mo.						autopsy performe		_
Vital	i <b>icien</b> : Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)		11
of <	hysic his ce Il dire	ို	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie			4   Nursing Ho	ome 5 Residen	ce 6 Other (Sp	socity) of his
n O	ing P	on:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injui (Month, Day		Wor		28d. Describe how	injury occurred	vunse
Sio	teath tor: / the f	icat	2 Accident investigatio 3 Suicide 6 Could not b				Yes 2 □ No			
Division	or Al	Certification:	4 Homicide determined		ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office		28t. Location (Stre City or Town,		Rural Route Number,
J	pitei ours a erei filled		29a. Certifier 1 Certifying Pt	veicien: To the best	of my knowledge, deat	th accounted at the time			(-)	
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: Atter this certificate his completely filled in by the funeral director, page	edical	(Check only one)	nysician: To the best on niner: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occur	red at the time, dat	e and place, and d	ue to the cause(s)
	omple	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Mo	nth, Day, Year)
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1	0		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	1.		( L L L L L	
(	,		H Far Rus	MD Su	yours He	spice	Blita	m MD		
	Sta		31. Date filed (Month, Day, Year)	All .	ar's Signature	1 × 1	- IV-1-			
	Registr	ar	APR 0 4 20	106 Littler.	o So figh	New York				

	1	For State Ragistrar	e of Maryland /		rtment of H			giene Reg. No. 006	10358
Physicia		Decedent's Name (First, Middle, Last)     ERMA MISSOURI	PICKENS				2. Date of Dea Month April 1	Day Year	3. Time of Death 4:10 P M
/Medic Examin	4	4a. Facility Name (If not institution, give street a			4b. City, Town, or	Location of Death	, <u>-</u>	4c. County of Dea	
	1 1	Oak Crest Care C				arkvill			imore
Funeral Director		5. Social Security Number 6. Sex 1 □ M 23	7. Age (In yrs. last to 87	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Dat July	v. Year) C	thplace (State or Foreign ountry) Virginia
E +		Usual Residence of Decedent				1	Dury	14/1510 (1650	
ith the Marylar or 28a-f ehow	۲	10a. State 10b. County MD Baltimo	10c. City, To		cation rkville				10d. Inside City Limits 1  Yes 2 XNo
the M 28a-f	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	
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2 hour	ted t	15. Decedent's Education	16	Sa. Deced	ent's Usual Occup	ation		16b. Kind of Business	/Industry
thin 7.	Completed	(Specify only highest grade complete lementary/Secondary (0-12)  Coll	eted) ege (1-4or 5+)		kind of work done of NOT use retired		king		
iled wi lygien her th		12 17. Father's Name (First, Middle, Last)		P	ostmast		- /Fina Adidala		l Service
an y allo & 12. 2 should be filed within and Mental Hygiene. Is marked other then raumatic event, If a Me	To Be		Anderson					Maiden Surname)  1 Nicely	
and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship (Type, Prin Julie Nicely-Niece	and the second		-			er, City or Town, State, r, Marylar,	
Page nent o		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal  □ Donation 5 □ Other (Specify)	20b. Place ceme	tery, crem	sition (Name of natory or other place Meth.CH C		Date 5,2006	20c. Location - City o	
permit. Departrimportri		21. Signature of Funeral Service Licensee	Forder		Name and Address	EV	ANS CH	APEL OF M kville,MD	EMORIES 21234
Physician		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	that caused the death. Do on each line.						Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)	ue to (or as a consequence	e of):					2 Hande
15 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-	Sequentially list conditions, b	Pheumo	1716					days
od d	Examiner	Sequentially list conditions, fary, backing to translation cause. Enter Undertrying Cause (Disease or injury that initiated events c.	Dementia						Jdays 575
of ou, contact the burial-transit			ue to (or as a consequenc	e of):					-0
cate be exi	dlcal	d							
The Coulds, T.C. BOX 00100, "The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	es, outcome of pregnancy Live birth 2  Fetal dea Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year
that the hold by detact	by Ph	Part II. Other significant conditions contributing	g to death but not resulting	g in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
w requires been sign should be		· · · · · · · · · · · · · · · · · · ·					1 🗆 1	/es 2 <b>5x4</b> 0 3 □ F	robably 4 Unknown
The law requate has been appeaded should	Completed						24a. Was autop perfo 1 Yes		utopsy findings available completion of cause of
Physician: The physician: The this certificate al director, page	Be (	25. Was case referred to medical examiner?					ath (Check only o	ne)	
To the Hospital or Attending Physician: The lawithin 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tlon: To	1  Yes 2  No Hospital  27. Manner of Death  ↑  Action	1   Inpatient 2   EH/	Outpatien  Time of Injury	28c. Injur Wor	4 Prursing P		dence 6 Other (Sp now injury occurred	ecify)
To the Hospital or Attending F within 24 hours atten death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Cuiarda 6 Could not be	Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tov	Street and Number or F vn, State)	tural Route Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Circck only one) 1 Secretifying Physician: 2 Medical Examiner: Or an	To the best of my knowled the basis or examination i manner stated.	ige, death and/or inv	e occurred at the tir restigation, in my o	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	.01		29c. Licens	_		29d. Date signed (Mor	
		I will hilling	ners		P 3	182		April 1,	2006
17		30. Name and address of person who complete			alther 1	stud B	alth	Aprill, one mo	21234
Sta Registi		31. Date filed (Month, Day, Year) APR 0 4 2006	32. Registrar's Signature						

	•	For State Registrar	State of Maryland	d / Depa		lealth and M	lental Hyg		10359
Physicia /Medica		1. Decedent's Name (First, Middle, Last LILLIAN B.PF					2. Date of Dear Month	Day Year 30, 2006	3. Time of Death 2:35 Рм
Examine		4a. Facility Name (If not institution, give  Pickers Gill  5. Social Security Number 6. Se		at histholous		r Location of Death <pre>ltimore</pre> <pre>If Under 24 Hrs.</pre>	O. Data of Birth	4c. County of Deat BaLTIM	ORE
Funeral Director			л 2 <del>Д</del> F 88	Yrs.	Months Days	Hours Min.	8. Date of Birth NOV • 15	, 1917 Ne	hplace (State or Foreign nuntry) W Jersey
death with the Maryland ms 23a or 28a-f ehow Lisual be Indiffed at	ctor	MD Balt	imore 10c. City	Balt	cimore				10d. Inside City Limits 1 ☐ Yes 3 No
ath with th	Funeral Director	10e. Street and Number 8523 Fowler Ave	enue			234		0g. Citizen of What Co USA	untry?
0036 ours after der ral', or items	ፍ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XX	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
Maryland 21215-0036 d 2 should be filed within 72 hours after th and Mental Hygiene. 77 is marked other than "natural", or its traumatic event, the Maximal Examplia	Be Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 1 2	cation le completed) College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retired ales Cle	ation during most of work ork	ing	16b. Kind of Business/ Departmen	
yland 2 build be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last)  Carl Bonas					a Selm	a	
Heal Heal		19a. Informant's Name/Relationship (T)  James Pritchard  20a. Method of Disposition  1 □ Burial 2 ★ remation 3 □ F	d. Sr-Son	17 No	-	on Road	-Timon	20c. Location - City or	rland 21093 Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: if item any injury or othe		. 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		22	2. Name and Addre	ss of Facility		Forest Hi	
S760, Medical are be executed Examiner and he burial-transit	cai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		ence of):	MIA	Je in en		est,	Approximate Interval Between Onset and Death
Cords, P.O. Box 687  w requires that the death certificate been signed by the attending phys should be detached for use as the	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d. 23c. If yes, outcome of pregnant 1 □Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)	,		23d. Date of del Month	ivery Day Year
rds, P.C	ed by Ph	Part II. Other significant conditions co	ntributing to death but not resu		nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribute to es 2 No 3 □ Pr	the cause of death?
II Record The law requested has been page 2 should	Completed	<u> </u>					24a. Was a autops perform	y prior to o	itopsy findings available completion of cause of 2 No
on of Vita ling Phyaician I. After this certifi	Certification; To Be	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	(Month, Day Year)	28b. Time o Injury	f 28c. Injur Wor M 1	y at k? Yes 2 □ No	me 5 □ Reside 28d. Describe ho	ence 6 □Other <i>(Spe</i> dow injury occurred	
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify sicien: To the best of my known	)			City or Town		
o the Hos vithin 24 hu o the Fur	Medical	(Check only 2 Medical Exemi	iner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my o	pinion, death occurr	ed at the time, d	ate and place, and due	to the cause(s)
		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print) Da	5705	P - 15	MAVCh	31,2006
Stat Registra	е	31. Date filed (Month Day, Year) APR 0 4 2001	2. Registrar's Siggat	70 / ,		W 65 21.	par		-1207

			1 - For Stete Registrar	State of Marylan		ertment of H tificate of t		Mental Hy	ygiene Reg. No.	16	0360
	Physici /Medio		1. Decedent's Name (First, Middle, La Ok B. Paik					2. Date of D	n 38,0	2006	3. Time of Death
	Examir Funeral Director	ner	4a. Facility Name (If not institution, given the second of	eneral NOSA	17 Tal last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	y fy	N/A	Countr	ce (State or Foreign y) On, Korea
	ס	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		y, Town or Local						d. Inside City Limits 1 ∑Yes 2 ☐ No
	h with the 23a or 28a st Le noti	al Director	10e. Street and Number 11 West 20th Stre	eet		10f. Zip Code 21218			10g. Citizen of United		y?
920	be filed within 72 hours after deeth with the Maryland tal Hygiena. Id other than "natural", or itams 23a or 28e-f show other than "natural" or itams 22a or 28e-f show event, i're Medical Evani, er must be recitified at	by Funeral	11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □ Yes 21 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ace - Americar ack, White, et ify: Korea	c.
Maryland 21215-0036	e filed within 72 ho al Hygiena I othar than "natur vent, Ine Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed)  College (1-4or 5+)  N/A	(Give life. C	lent's Usual Occupi kind of work done o DO NOT use retired Maker	ation furing most of wor )	king .	16b. Kind of E	Business/Indu	stry
yland	should be filed ind Mental Hygi markad othar umatic event, I	To Be C	17. Father's Name <i>(First, Middle, Last,</i> Unknown				18. Mother's Nan Unknown	1			
	ges 1 and 2 should nt of Health and Mer if item 27 Is marks or other traumatic		19a. Informant's Name/Relationship ( Mr. David D. Pai	k (Son)	3110	g Address (Street a Krista ( sition (Name of			City Ma	ryland	, 21042
Baltimore,	t. Partmer		20a. Method of Disposition  1	Removal from State Du	ametery, crem laney	valley Me	m. Marc	h 31,20	1	onium,	Maryland
Ba	Depa Impo any in		23a. Part1. Enter the disease, or comshock, or heart failure. List only	Legun	Z 3.	SO TOTK L	Cau IIIIC	TITUIL MG	iryiana,	21093	Ctr.P.A.
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.  a. CARDIDE  Due to (or as a consequ	ULM					li C	nterval Between Onset and Death
8760,	icate be executed by physicien and contral-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. CONGES Due to (or as a consequ	TIUE uence of): ERAL uence of):	-	ART F EUMO	, -	IRE		
.O. Box 6	the death certil y the attanding iched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)				ate of delivery onth D	ay Year
rds, P	sign d be	ρ	Part II. Other significant conditions of	contributing to death but not resu	ulting in the un	derlying cause give	en in Part I.		tobacco use con Yes 21☑10o		cause of death?
Vital Records,	The ite h	Completed						24a. Was auto perf 1 \( \text{Yes}		Were autops prior to comp death? 1 Yes 2	y findings available eletion of cause of
Z.	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 1	ER/Outpatient	3 □ DOA Othe	26. Place of Dea		one) idence 6 □Oti	her (Specify)	
Division of	tending leath. tor: After the funer	Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y		28d. Describe	how injury occu	rred	
DİVİ	ا الله الله		4 Homicide determined	building, etc. (Specify	′)			City or To	(Street and Num own, State)		
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier  (Check only 2 Medical Examone)  29b. Signature and We recrifier	nysicien: To the best of my knowniner: On the basis of examinat and manner stated.	ion and/or inv	estigation, in my op	inion, death occur	red at the time	date and place,	and due to th	ne cause(s)
	J. Will		1 Bley	udomis	-	04.	204)		03 28	106	
	9		30. Name and address of person who 4115 RI + Chu	completed cause of death (Item	A 1	Park	ma	2122	5		
	Sta Registr	-	31. Date filed (Month, Day, Year)  APR 0 4	32. Registrar's Signat		Cartes	,				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>2006 **Physician** April 1, 3:35PM Pohlman, Jr. Arthur Walter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ivy Hall Nursing Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Davs | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 28, 1918 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1**√**M 2□F Months Maryland 87 Director 220-09-3624 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 23a or 28a-f ehow the Medical Examiner; just be notified at 1 ☐ Yes 2 No **Funeral Director** Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21236 9606 Dunkeld Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 No
If Yes. Give or items filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 ₩ Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7; Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "na eny injury or other traumatic event, In a Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) Printing Company Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) M. Brockman Helen W. Pohlman, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9606 Dunkeld Court Baltimore, Maryland 21236 William Pohlman- Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/5/06 Moreland Memorial Baltimore, Maryland Leonard J. Ruck, Inc. Heather Cain 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** emphisa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a con equence of): Examiner ed by the e tending physicien and detached for use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 ☐ Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an PiFea De Remalm 1 Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier ONAs 4/3/0 3146 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of fute 308, BALTIMORE MD 21201 , SZI N. ENTAW 1Mt18AH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** MARCH 10:56 PM Ann Marie Ramsingh 27 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE CITY N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | MAR | 8, 1971 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 35 Director Trinidad Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. Count 10d. Inside City Limits si Hygiene. Jother than "natural", or Itema 23a or 28a-f show vant, the Madical Examinat must be notified at Yes 2□No N/ABaltimore Maryland Direct the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6903 Reisterstown Road 21215 Trinidad Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Asian Indian ٤ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Store Assistant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental Mental Bhatlal Sammy Dolly Sammy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If itsm 27 is sny injury or other tra-Kanhai Sanowar/Fiance 6903 Reisterstown Road Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 4/1/06 Baltimore, MD 21. Signature of Funeral Service Ligensee

22. Name and Address of Facility MacNabb Fune

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final DAYS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DAY S CAVERNOUS SINUS THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 4 Pregnant at time of death 5 Other (specify) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No page 2 s certificete has 1 Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this funeral dir 27. Manper of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending efter death.

Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours eft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2006 CINCOLDNI, MT REJ-000 F'5, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MT EUGENIO CINGOLANI SINA! HOSFITAL BALTIMORE OF 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

		ľ	For State Registrar		epartment of Health and M Certificate of Death	lental Hygien Regun	111111111111111111111111111111111111111	3
1	Physicia		1. Decedent's Name (First, Middle, Last)  James L. Reh	an		2. Date of Death March 31	3. Time of Deal //:/5A	
	/Medic Examin		4a. Facility Name (If not institution, give stree 1811 Beechwood	et and number)	4b. City, Town, or Location of Death Essex		c. County of Death	
8.	Funeral Director		214-50-5000	7. Age (In yrs. last birtho	Months Days Hours Min.	8. Date of Birth (Month, Day, Year Aug. 11, 1	9. Birthplace (State or For MAryland	eign
	e Maryland a-f ehow lied at		Usual Residence of Decedent  10a. State 10b. County  MD Baltimo	re Essex			10d. Inside City Lir 1 ☐ Yes 2 Ž	
	th with the 23a or 28 as the ma	Funeral Director	1811 Beechwood		10f. Zip Code 21 221	US		
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, III a Modical Examinar must be notified at	by	11. Marital Status 12.  1 XNever Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces?  1	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes	Hican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, I're It offer	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12th	ompleted) ((	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)  nposite Tech	una	Kind of Business/Industry	
land 2	ild be filed lental Hyg ked other ilc avent, I	To Be C	17. Father's Name (First, Middle, Last) Edward Rehan		5	e (First, Middle, Maide t Hofferb		
	and 2 should be a alth and Mental is 127 is marked o or traumatic ave		19a. Informant's Name/Relationship (Type Ann Chaney	1:	Mailing Address (Street and Number or Rus 209 Bayside Road	Baltimor	e MD	
Baltimore,	permit. Pages 1 and 2 Department of Health : Important: if Item 27 if any Injury or other tre		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	Crematory or other place) Lawn Cemetery 4/	4/06 Ba	Location City or Town, State  Lltimore MD	
Balt	permit. Depertr Import		21. Signardie of Funeral Service Licensee	onnelly	22. Name and Address of Facility 3	al Home c	of Essex 21221	
1	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	tions that caused the death. To no cause on each line.  Due to (or as a consequence of		or respiratory arrest.	Approximate Interval Betwee Onset and Deat	n th
8760,	ate be executed hysicien end the burial-transit	cal Examiner	Sequentially list conditions, it may lead to mind a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence of				
.O. Box 68	The law requires that the death certificate be executed its bas been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death  9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year	r
Ω.	uires that I signed by ild be deta	by	Part II. Other significant conditions conte	ibuting to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of deat 21 No 3 Probably 4 Unki	
of Vital Records,	The law requir ste has been si page 2 should	Completed				24a. Was an autopsy performed:		ilable e of
of Vita	Physician: this certific al director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	spital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing H	ath (Check only one) tome 5 Residence 28d. Describe how in		
Division	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined		jury Work?  M 1 Yes 2 No	28f. Location (Street City or Town, St	and Number or Rural Route Number (afe)	r,
Ω	To the Hospital c within 24 hours af To the Funeral D completely filled in	edicai Ce	(Check only 2 Medical Examina	er: On the basis of examination and	death occurred at the time, date and place	a, and due to the cause arred at the time, date a	a(s) and manner as stated. and place, and due to the cause(s)	
	To the I	Med	one)  29b. Signature and title of certifier	and manner stated.	29c. License number	2 29d.	Date signed (Mgnth, Day, Year)	
	5		ROBERT	ppletted cause of death (Item 23a) (	Type, Print) 9110 PHILA	DELT HIA	RR BALT 190 212	257
D	St Regis HMH 17 Rev 1/	-	31. Date filed (Month, Day, Year)  APR 0 4 2006	32. Registrar's Signature	hack)			

**ORIGINAL** 

			1 - For State Registrar	State of	Marylan		artment rtificate			and M	lental Hy	giene Reg! No.	6	1036	5 13
	Physici	an	1. Decedent's Name (First, Middle, Las	t)			-				2. Date of De Month	Day	Year	3. Time of	Death
	/Medic					Robert					March	30, 200		2:36	PM
	Examir	er	4a. Facility Name (If not institution, give		per)		4b. City,	_	Location of	of Death		4c. County			
			7906 Stone Hearth 5. Social Security Number 6. Se		. Age (In yrs.	(act hirthday)	If Under	Sev	ern If Under:	24 Hrs	8. Date of Bird		Aru		
	Funeral Director		1	_XM 2□ F	7 1	Yrs.	Months	Days	Hours	Min.	(Month, Da	iy, Year)		place (State o. ntry) exas	r ⊢oreign
	AA		240-50-5194 Usual Residence of Decedent		/1						UCL 1,	1934	1	exas	
	Maryland -f show lind at		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Cit	y Limits
	Ma-f-	ctor	Maryland Anne Aru	ınde1			Severi	a						1 🗌 Yes	2x No
	ous after death with the Marylar rai', or items 23a or 28a-1 show Examinat cutal be notified at	by Funeral Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?	
	23a	la	7906 Stone Hearth	n Road				211					ted	States	
	r dez	nue	11. Marital Status	12. Was Deced Armed Ford	es?	.S. 13.	Was Deced f Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	14. Rad Blad	e - Ameri	can Indian, etc.	
36	hours after tural", or ite	y Fi	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 If Yes, Give	□ No	0.6	1 ☐ Yes 2	No X	Specify:			Specif		• •	
5-0036	72 hours "natural",		15. Decedent's Ed		es1956 <b>-</b>	-	dent's Usua	I Occupa	tion			16b. Kind of B		ite	
15		Completed	(Specify only highest gra	de completed)		(Give	kind of wor DO NOT us	k done a e retired	luring mosi )	t of work	ng	166. Killu of B	12111922/11	idustry	
2121	within lene. than	ЩO	Elementary/Secondary (0-12)	College (1-4	for 5+)	1	Office					Departm	ent	of Def	ense
D	e filed within al Hygiene. I other then " vent, the Me	BeC	17. Father's Name (First, Middle, Last)			1			18. Mothe	r's Name	(First, Middle,	, Maiden Suman	10)		
an	lid be lental rked c	To B	David Allen	Roberts					Eli	zabe	th	Schaub			
Maryland	2 should be and Mental le marked aumatic ev		19a. Informant's Name/Relationship (7	Type, Print)		19b. Mailir	ng Address	(Street a	ind Numbe	r or Rura	Il Route Numbe	er, City or Town,	State, Zij	o Code)	
	무를 2 급		Peggy Roberts/wife	<u> </u>		7906	Stone	e He	arth	Road	Seve	rn, Mary	1and	21144	
ore	@ C		20a. Method of Disposition  1 X Burial 2 Cremation 3	Demonstran C		Place of Dispo cemetery, crer	sition (Nam natory or of	e of her place	9)		Date	20c. Location -	City or T	own, State	
Ĕ	Page nent ant: It		4 □ Donation 5 □ Other (Specify		Ar1	ington	Natio	ona1	Ceme	5/9	/2006	Arling	ton,	Virgi	nia
Baltimore,	permit. Pages Department of I Important: If ite eny injury or o		21. Signature of Funeral Service Licen	see		22 D	Name and	d Addres	s of Facilit	y 21 F	lome & (	Cremator	v P	Δ	
8	Dep de de de de de de de de de de de de de		Quarita RH	roman		1	411 A	nnap	olis	Road	Odent	ton, Mar	ylan	d 2111	3
			23a. Part . Enter the disease, or comp shock, or heart failure. List only	olications that cau	used the deat	h. Do not ent	er the mode	of dying						Approximate Interval Bety	veen
	Physician :		Immediate Cause (Final disease or condition	m.	la	3 ta	hic		10	2	cres	us G	S	Sinset and E	leath leav
	/Medical Examiner		resulting in death)	Due to (o	r as a conseq	uence of):			4					0	
A.	L Xaiiiiilei		Sequentially list conditions,	b											
	be sit	Examiner	Sequentially list conditions, in the sequential cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a conseq	juence of j:									
Jar	be executed iicien and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or	r as a conseq	luence of):	_	_					-		
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687	icate be physici s the bu	ge		, d.			_							2-1	
Box (	eath certifical attending phy I for use es th	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco								23d Da	e of deliv	erv	
ă	death e atten	clar	in the past 12 months?		th 2∏Feta nt at time of d		Ectopic pre Other (spe						nth	•	'ear
0	the ache	hysi	9 Unknown	9□ Unknov	vn										
٩,	w requires that the sbeen signed by th should be detache	Completed by Physician/Med	Part II. Other significant conditions of	ontributing to dea	th but not res	utting in the u	nderlying ca	luse give	n in Part I.		23e. Did to	obacco use cont	ribute to t	he cause of de	eath?
rds	quire on sig uld b	ed b									1 🗆 🗅	Yes 21 No	3 🗌 Prol	bably 4 □U	Inknown
၀	- Q 76	plet									24a. Was	an / 24b.	Were auto	opsy findings a	available
8	0 2 0	E										rmed?	death?	mpletion of ca	ause of
ital	ician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	Check only o		1 1 63	224110	
<b>†</b> \	S	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗆 Inj	patient 2	ER/Outpatier	nt 3 DO	A Othe	ar: 4 □ Nu	rsing Ho	ne 5 Resid	dence 6 □Oth	er (Speci	fy)	
0	ding Ph h. After th funeral		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	1 2	Bc. Injury Work	at		28d. Describe f	how injury occur	ed		
Si O	ttending death. ctor: After y the funer	catle	2 ☐ Accident investigation				М		Yes 2 □ I	No					
Division of Vital Records,	ter di	Certification:	3 Suicide 6 Could not be 4 Homicide determined	289. Place o	f Injury - At hi g, etc. (Specif	ome, farm, str fy)	eet, factory	office			28f. Location (3 City or Tox	Street and Numb vn, State)	er or Run	al Route Numi	ber,
	ors af	ပိ	V							10					
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	ysician: To the bas niner: On the bas and manne	is of examina	owledge, deat ition and/or in	h occurred a vestigation,	in my op	e, date an pinion, dea	d place, a th occurr	and due to the ed at the time,	cause(s) and ma date and place,	inner as s and due t	stated. o the cause(s)	)
	ithin to the other	Med	29b. Signature and title of certifier	and manne	or stated.		29c	License	number			29d. Date signe	d (Month,	Day, Year)	
	+ ≥ + 8		16. N									Marc	10	3/5/	006
	IXAL		30. Name and address of person who	completed cause	of death /lice	n 23a\ /Tuno	Prin# >	р3	9041	1	7 -	(= (, 0	~1~	2	
	10,		30. Name and address of person who	CADD		305	1	05 K	ita	1	DY	re ~	216	100	mic
71	Sta	te	31. Date filed (Month, Day, Year)	32. Be	gistrar's Signa	ature						1 - (		-	<del>ノ</del> ー
	Regist	ar	APR 0 4 20	106	ر ندانکانی	AF A	and I								

		For	State of	of Marylar		artment	of He	alth and	•		e On o	10000	
		1 - State Registrar			Cei	rtificate	of D	eath	10.5-4-	Reg. N	0.000	10000	_
Physic	ian	Decedent's Name (First, Middle     Decedent's Name (First, Middle							2. Date of Month	n D	ay Year		A
/Med		Robert A. Russ  4a. Facility Name (If not institution		ımher)		4h City T	Town or I	ocation of Dea	Marc		2006 c. County of Dea	7.50 1	_
Exami	iner	4 New Kent Co				15. G.,	_	onsvil			_		
Funeral	ere.	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hi		of Birth h, Day, Year		altimore rthplace (State or Foreig country)	חנ
Director		577-09-4004	10XM 2□ F	88	Yrs.	Months	Days	Hours Mi	Oct.	14,	1917 i	Maryland	
and *		Usual Residence of Decedent  10a, State  10b. County		10c. Ci	ty, Town or Lo	cation						10d, toside City Limits	
Maryli f sho	ō				,			• • •				1 ☐ Yes 2 No	
288-	Director	MD Balt  10e. Street and Number	imore			10f. Zip	Onsv:	ille		10g. C	itizen of What C	ountry?	
death with the Maryland me 23s or 28s-f show		4 New Kent Cou	ırt				2	1228		Un	ited Sta	atos	
deat	Funeral	11. Marital Status		edent Ever in U	J.S. 13.	Was Decede			(Specify Yes of		14. Race - Am Black, Wh	erican Indian,	
or its	y Fu	1 ☐ Never Married 2 Marr	ied 1 X Yes If Yes, G	2 No		1 ☐ Yes 2			orto i nodir, oto	,		White	
2-UUSO 72 hours after naturel', or ite	d by	3 Widowed 4 Divorced	Year or i	Dates:		dent's Usual							
within 72 ene. then "ne!	Completed	15. Deceden (Specify only higher	st grade completed		(Give	kind of work	k done dui e retired)	ring most of w	vorking		Kind of Busines: ilroad	s/industry	
y with	E	Elementary/Secondary (0-12)	College 4	(1-4or 5+)				Liaiso		1	tirement	t Board	
othe	a)	17. Father's Name (First, Middle,	Last)			<b>,</b>			ame (First, M			c_boara_	_
vid be fill Mental H irked oth	To B	William G. Rus	ssell					Mary	E. Wh	ite			
Daltimore, Maryland ZIZIO-0030 permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "naturel", or iteme 23e or 28e-f show any njury or other traumatic event, the Medical Examination must be notified at any.	ľ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street an	d Number or I	Rural Route N	umber, City	or Town, State,	Zip Code)	
e, ro		Margaret A. Ru	issell W	ife				ct, Cat			D 21228		
Ses 1 tof H if ite		20a. Method of Disposition 1X Burial 2 ☐ Cremation	3 ☐Removal from		Place of Dispo cemetery, crer	natory or otl	e or her place)	1	Date	20c. l	Location - City o	r Town, State	
Salumor semit. Pages Separtment of mportent: if it iny injury or o		4 Donation 5 Other (S		Mer	adowrid norial	Park		3-2	29-2006	E1	kridze.	MD	
Department of the post of the		21. Stonature of Funeral Service	Licensee	las X	110	Name and	Address	or Facility An	nbrose	Funer	al Home,	Inc.	
Away 23		23a. Part1. Enter the disease, or shock, or heart failure.	mplications that	used the	th. Do not ent	er the mode	TPHUI	such as cardi	iac or respirate	Arbu	tus, MD	Approximate	_
Dhysisian	ı	tmmediate Cause (Final	only one cause on	each line.	Merch	. 11	1111	0 L	1/111	,		Interval Between Onset and Death	
Physician /Medical	_	disease or condition resulting in death)	a	(or a consec	quence of):	- 14	ma.	1 Jan	wie				
Examiner	ı	On a second to the second to the second		Kun	of We	hhr	10 1	clein	11			musyeau	,
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to	(or as a consec	quence of):	1			- V			9	
be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	/24.22.2.22222									
ate be executed aysician and he burial-transit	calE	,	500 10	(or as a consec	quante oi).								
DO (			d										-
ath certifica	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		itcome of pregn		7-					23d. Date of de	alivery	
death death e atten	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	birth 2 ☐ Feta nant at time of c		Ectopic pre Other (spe					Month	Day Year	
at the by the stacke	hys	9 Unknown	9□ Unki			-							
The Cords, F.O. Box of The law requires that the death certificate has been signed by the attending phage 2 should be detached for use as it.	þ	Part II. Other significant condition	ns contributing to	death but not res	sulting in the u	nderlying ca	iuse given	in Part I.			_	to the cause of death?	
w requires to been signed should be	eted								-	1 ☐ Yes 2	ZIENO 3LIP	robably 4 Unknow	1
has has	ompieted								-   ;	Was an autopsy performed?,	24b. Were a prior to death?	utopsy findings available completion of cause of	Θ
- (0	ပိ	05 W-							1 🗆 Y	es 200 N	o 1 Ye		
90 (6)	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospitat:	Inpatient 2	] ER/Outpatier	nt 3 🗆 DO/			eath Check o		6 ☐Other (Spe		
	11-	27. Manner of Death	-	of Injury oth, Day Year)	28b. Time of		Bc, Injury a Work?				ury occurred	ecity)	
Attending r death. ector: After by the fune	atio	1 Matural 5 ☐ Pendin 2 ☐ Accident investig	gation	illi, Day real)	Injury	М		s 2□No					
INISION  or Attending after death. Director: Afte	ertification:	3 Suicide 6 Could 4 Homicide determ	inod 288. Plac	e of tnjury - At h ling, etc. (Speci	ome, farm, str	eet, factory,	office		28f. Locat City o	ion (Street a	nd Number or F	Rural Route Number,	
urs af	O	200											
DIVISIO  To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edicai	29a. Certifier 1 Certifier (Check only 2 Medical one)	g Physician: To th Examiner: On the l and ma	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	n occurred a vestigation,	it the time, in my opir	date and pla ion, death oc	ce, and due to curred at the t	the cause( ime, date ar	s) and manner a nd place, and du	s stated. e to the cause(s)	
vithin To th compl	₩	29b. Signature and title of pertue	11/1/11			29	License r	number			ate signed (Mon		
		> Nou	ejinec			1	1101	013			-27-		
15+1		30. Name and address of person	who completed cau	se of death (Ite		Print)	יררו	7000	DED OS	Bush	DA Ro	LTO 21208	
( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	táte	31. Date filed (Month, Day, Year)	32	Registrar's Sign	Suite }	ales	1//	IVEIS	SICIUS!	VVVV	ווכו- שי	40 21-00	
Regis		APR 0 4	2006	Registrar's Sign	D. Allen								

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	23a. P.	
	Immed disease resultir	θ
dicai Examiner	Sequer if any, I cause. Cause that init resultin	(
vsician/Me	IF FEM 23b. W in 1	1
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ertification: ]	27. Mar 1 2 2 2 3 2 4 2	
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	Amend item#5,perFH,085	e or Print in 1	Black Ind	delible Ink	. Ensure	All C	Copies A	e Legible	
	1 - For State Registrar	ate of Marylar	Cer	tificate of	Death	u Mei	Reg.		10366
	Decedent's Name (First, Middle, Last)						Date of Death		3. Time of Death
1	SARAH			BI	NACA			Day Year	
r	4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town,	or Location of De	_		4c. County of De	ath
	THE JOHNS HOPKINS	HOSPITAL		BALTI	MORE !	CIT	7	N/A	
	5. Social Security Number 6. Sex	7. Age (In yrs.	, ,	If Under 1 Year Months Days	If Under 24 H	in. 8.	Date of Birth (Month, Day, Ye	9. B	irthplace (State or Foreign Country)
	147–16– <del>5433</del>	2X* 8:	1 Yrs.				March 8	, 1925 N	ew Jersey
	Usual Residence of Decedent  10a State 10b County Baltimore	10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
5	MD Baltimore	I A	Arbutus						1 ☐ Yes 2 No
2	10e. Street and Number			10f. Zip Code			10g.	Citizen of What (	Country?
2	1115 Linden Ave.			2122	7			U. S. A	•
0	11. Marital Status 12. V	Vas Decedent Ever in U	J.S. 13. V	Vas Decedent of f Yes, specify Cub	Hispanic Origin?	(Specify	Yes or No-	14. Race - An Black, Wh	nerican Indian,
	1 ☐ Never Married 21 Married 1	☐Yes 2∑No fYes, Give		Yes 2 No	Specify:		21., 010.)	Specify:	White
0	3 Widowed 4 Divorced Y	ear or Dates:							
2	15. Decedent's Educatio (Specify only highest grade con	n npleted)	(Give I	lent's Usual Occu kind of work done DO NOT use retire	during most of	working	161	o, Kind of Busines	s/Industry
completed by runeral bilector	Elementary/Secondary (0-12)	College (1-4or 5+)		Clerk	T.			Iifo '	Insurance
מ	17. Father's Name (First, Middle, Last)		1110	OTCIR	18. Mother's	Name (Fi	irst, Middle, Mai		rnsurance
0	Charles I. Parkin				Elean	nor I	Book		
-	19a. Informant's Name/Relationship (Type, F	,						ity or Town, State	, Zip Code)
	Durwood Rinaca, hu			Linden	Ave. Ba		more, MI		
	20a. Method of Disposition 1 ☐ Burial 2XCremation 3 ☐ Remo	20b.	Place of Dispos cemetery, crem	sition (Name of natory or other pla ndel Cre	ce)	Date		Location - City o	
	4 □Donation 5 □ Other (Specify)	WE	est Alui	nder Cre	natory	04-0	03-06	Odenton,	MD
ı	21. Signature of Buneral Service Licensee	7	22	Ambrose	Funeral	Home	e, Inc.		
_	Effektion !			1328 Sul	phur Spi	ring	Rd. Art	outus, M	
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one care	ins that caused the dea luse on each line.	th. Do not ente	er the mode of dyi	ng, such as card	diac or re	spiratory arrest,		Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death)	SUBARA	ACHNO:	ID He	MORBH	AGE	-		20 hours
	Todaking in dodairy	Due to (or as a consec				1			10 days
5	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	Vascu	KIK M	cciden	21			10 days
Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	LUNG C	ANCE	2					4 months
E X	resulting in death) Last	Due to (or as a consec	quence of):						
ealcal	d	<u>.</u>							
2	IF FEMALE:								
riyəlcidirin	23b. Was decedent pregnant 23c. If	yes, outcome of pregn □Live birth 2 □ Feta		Ectopic pregnanc	у			23d. Date of d Month	elivery Day Year
2		I□Pregnant at time of o P□Unknown	death 5□	Other (specify)				Month	Day real
	Part II. Other significant conditions contribu	iting to death but not re-	sulting in the un	nderlying cause of	ven in Part I		23e. Did tohac	co use contribute	to the cause of death?
2		•	•	,			1 Yes	2 No 3 1	Probably 4 Unknown
010						- -	24a. Was an	24h Were	autopsy findings available
Completed						-	autopsy performed	prior to	completion of cause of
D	25. Was case referred to medical				26 Place of I		1 ☐ Yes 2 🔀 heck only one)	(No 1 1 Ye	os 2 No
2	examiner? 1 ☐ Yes 2 ☑ No Hospi	tal: 1 Minpatient 2	] ER/Outpatient	t 3 DOA Ot	205			e 6 □Other (Sa	necify)
	27. Manner of Death 28	Ba. Date of Injury (Month, Day Year)	28b. Time of Injury				Describe how		
31	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,u.y		Yes 2 □ No				
	3 ☐ Suicide 6 ☐ Could not be 28 4 ☐ Homicide determined 28	Be. Place of Injury - At h building, etc. (Speci		eet, factory, office		28f.	Location (Stree City or Town, S	t and Number or i	Rural Route Number,
Medical Certification:	000 00 to 100 to								
2	29a. Certifier 1 Certifying Physicia (Check only one) 2 Medical Exeminer:	<ul> <li>To the best of my kn</li> <li>On the basis of examinand manner stated.</li> </ul>	owledge, death ation and/or inv	occurred at the treestigation, in my	me, date and pla opinion, death o	ace, and ccurred a	due to the caus it the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
ğ	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d.	Date signed (Mo	nth, Day, Year)
	1	leoical D	CYTOP	RCC	5-000	,			1,2006
	30. Name and address of person who comple							II MOR J	2006
					DN. Was	CFE	STREET	BACTIMARA	MARYLAND ZIZO
	31. Date filed (Month, Day, Year)	32 Registrar's Sign	ature A	antis			-1,500	10140	7
	APR 0 4 2006	Por 3150 8	C. Page	Dell'all					

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Stat Registra

			For State Registrar	State of I	Marylan	-	artment o				giene Reg. No. 0 0		10367
	Physici	an	1. Decedent's Name (First, Middle, Las Esther M.	_						2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give		er)		4b. City, Tow	n, or Local	tion of Death	March	4c. County of		6:20 AM M
			Keswick MultiCare					Balti				N/	
- 1	Funeral Director		210 22 0000	9x 7. □M 2√√xF	Age (In yrs.	93 Yrs.		ays Hou	nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da Dec. 2	y, Year) 0, 1912		place (State or Foreign htry) yland
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation					1	0d. Inside City Limits
	a-feh	ctor	Maryland	N/A			Bal	timor	e				1 <b>XX</b> Yes 2 ☐ No
	itied within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinar rount be molified at	Completed by Funeral Director	10e. Street and Number 700 W. 40th Stree	t			10f. Zip Co		21211		10g. Citizen of W		ntry? [SA
	after death w or items 23a miner must	Inera	11. Marital Status	12. Was Decede Armed Force		.S. 13.	Was Decedent If Yes, specify	of Hispanio	c Origin? (Spe xican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race		an Indian,
036	be tited within 72 hours after de ital Hygiene. od other than "natural", or item: event, Ira Medical Examiliaer.	by Fu	1 ☐ Never Married 2 ☐ Married 3 📆 Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date	_		1 ☐ Yes 2 🛣		ecify:		Specify:		hite
5-0	72 hours "natural",	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	edent's Usual O	one during	most of worki	ing	16b. Kind of Bus	siness/Inc	dustry
Maryland 21215-0036	e filed within al Hygiene. cother than '	ompl	Elementary/Secondary (0-12)	College (1-4	or 5+)		oo not use re omemake:				In	own	home
nd	al Hyg d other	Be	17. Father's Name (First, Middle, Last)					18. N			Maiden Sumame	3)	
ryla	2 should be f and Mental H is marked of aumatic eve	To	Harry Musgrove  19a. Informant's Name/Relationship (	Tuno Orint)		10h Mail	ing Address (Ct	rant and Ali		a Brown	er, City or Town, S	Cénen Tin	Codel
	s 1 and 2 should Health and Men Item 27 is marke other traumalic		Regina Rouchard	уре, Епп			-				Marylan		
ore,	es 1 a of Hea if Item ir othe		20a. Method of Disposition  1X□Burial 2 □ Cremation 3 □	Removal from Sta		Place of Disp emetery, cre	osition (Name o	f place)	1	Date	20c. Location - 0		
Baltimore,	it. Pag ritment ritant: i njury o		*4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Licen	"	May		pel Ceme			/2006	Baltim	ore,	Maryland
Bal	permit. Pages 1 and 2 Department of Health as Important: If Item 27 is any injury or other trac		Signal Funeral Service Con	Carper	lis	Ĭ	2. Name and A Burgee-I 3631 Fa	lenss L1s R	-Seitz oad I	Funera Baltimo	1 Home, re, Mary	Inc. land	21211
			23a. Part 1. Enter the disease, or com- shock, or heart failure. List only	one caute on eac	h line.	h. Do not en	iter the mode of	dying, suc	h as cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
0	Prysician /Medical		Immediate Cause (Final disease or condition resulting in death)		as a conseq		ARDI	omy	OPATI	17			Mouths
8	Examiner		Sequentially list conditions,	Artel	roscl	erotic	care	dock	saula	e de	seose		years
40	be sit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):							0
ري ري	execut an and rial-tran	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):							
66 6:30AM	n certificate be executed anding physician and use as the burial-transit	edlcal		d								_	
× 6	ath certific attending p for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date	of delive	ery
3 - B	atte for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		n 2□Feta t at time of d n		□Ectopic pregn □ Other (specif				Mon		Day Year
3. P.O.	es that the digned by the		9 ☐ Unknown  Part II. Other significant conditions c	ontributing to deat	h but not res			e given in F	Part I.	23e. Did t	obacco use contri	bute to th	ne cause of death?
rds	v requires been sign	ed by	Clostridion	& FFicel	ed	larrh	nea, 11	Ma	etable	10	res 2□No	3 ☐ Prob	ably 4 Unknown
C	law renas bee	Completed								24a. Was	osy p	rior to cor	psy findings available mpletion of cause of
2 <u>e</u>		e Con	25. Was case referred to medical							1 Yes	2 No 1	eath? Yes	2 No
TA =	Physician: this certificanal director,	0	examiner?	Hospital: 1 Inp	atient 2 🗍	ER/Outpatie	ent 3 DOA			n <i>(Check only c</i> me 5 ☐ Resid	<i>nne)</i> dence 6 □Othe	r (Specif	y)
M 2	tending Ph leath. tor: After thi the funeral	on: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury		Injury at Work?			now injury occurre		
Sisio	if or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of	Injury - At he	ome, farm, si	M treet, factory, of	1 ☐ Yes	-		Street and Numbe	r or Rura	Il Route Number,
95 S	in State	Certl	4 Homicide	building	, etc. (Specif	y)				City or Tox	vn, State)		
24	Ho Fur P	Medical	29a. Certifier (Check only one)  19 Certifying Ph 20 Medical Exam		s of examina								
	To the How within 24 h To the Fur completely	Me	29b. Signature and title of certifier	0	<u> </u>		29c. Li	cense num	ber		29d. Date signed	(Month,	Day, Year)
	1		Oxerelall	JU-al	ell	N	0	250	043		03/31/	20	206
			30. Name and address of person who Kendal R Faulla	completed cause	of death (Item	n 23a) (Type N . CS	parles S	Stree	+/Suc	utc 209/	Balto	M	21204
	Sta		31. Date filed (Month, Day, Year)	32/ Reg	istrar's Signa	nture As	1 V .		1	/			
	Registi	rar	APR 0 4 2	2006	MARINE -	Ar Le	DEASE.						

				For State Registrar	State of Marylar		ent of Health and ate of Death	d Mental F	lygiene Reg. No.	006	10368
		Physici		Decedent's Name (First, Middle, Last)     Elizabeth Ann Smit	-h			2. Date of Month	Death Day	Year - 2006	3. Time of Death
4		/Medi Examir		4a. Facility Name (If not institution, give si	treet and number)	4b. C	ity, Town, or Location of D		1	ounty of Death	
		Funeral Director		5. Social Security Number 6. Sex 1	M 200 HOSPITO 7. Age (In yrs.	last birthday) II Un Yrs. Month	Moseda 16  der 1 Year   II Under 24 h  hs Days Hours N		Birth (Pay, Year) 10,1937	9. Birthi Cou Mary	OSE place (State or Foreign ntry) Land
		h the Maryland r 28e-f ehow	io.	Usual Residence of Decedent  10a. State  10b. County  Maryland Baltimore		ty, Town or Location					10d. Inside City Limits 1 ☐ Yes 2 \ \
	:	or 28e	Funeral Director	10e. Street and Number			Zip Code		10g. Citizer	n of What Cou	ntry?
F		ne 23s	eral	71 Yew Road  11. Marital Status 1	2. Was Decedent Ever in U		1221	(Specify Yes or	U.S.	A. Race - Ameri	can Indian
Zabeth	036	within 72 hours atter deeth with the Maryland ene. Then "naturel", or teme 23a or 28e-f ehow na Medical Eventiner must be notillied at	by	1 X Never Married 2  Married 3  Widowed 4  Divorced	Armed Forces?  1 Yes 22 No If Yes, Give Year or Dates:	II Yes, s	cedent of Hispanic Origin? specify Cuban, Mexican, Pi s 20tho Specify:	uerto Rican, etc.)		Black, White, Decify: Whi	etc.
120	1215-0	rithin 72 hours ne. hen "naturel", ne.Medical Evel	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	life. DO NO	work done during most of	working		of Business/In	dustry
W	ind 2	be filed itel Hygi od other event, I	To Be Cor	8 17. Father's Name (First, Middle, Last) John Robert Smith		teller	_	Name (First, Midden C. Hei			
17 Th	Mary	1 and 2 should Heelth and Mer Iom 27 is marke ther traumatic	F	19a. Informant's Name/Relationship (Type) Joseph Schmitt (Nex	_	L.	ess (Street and Number of Drook Way, 1				Code)
2	ore,			20a. Method of Disposition  20x Burial 2 ☐ Cremation 3 ☐ Re	20b. F	Place of Disposition (incometery, crematory)	Name of or other place)	Date	-	tion - City or To	own, State
0 1	Itim	permit. Peges Department of importent: if i eny injury or t ance.		4 □ Donation 5 □ Other (Specify)  21. Signature of European Control		dens Of Fa					, Maryland
	Ba	Ped Ped Ped Ped Ped Ped Ped Ped Ped Ped	1	1/2		140	and Address of Facility Bruzdzin: 7 old Fasteri	ski Fune n Avenue	ral Hom . Essex	ne, P.A K. Marv	land 21221
<b>1</b> h	1	Physician /Medical Examiner		23a. Part 1 Ener the disease, or complice shock or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a consequence)	al He quence of): Tumor	matornation		r arrest,		Approximate Interval Between Onset and Death
es me	8760,	cate be executed physicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last	Due to (or as a conseq						
Lax	O. Box 6	death certification of for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Bc. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	al death 3 Ectopic	c pregnancy (specify)		23d	d. Date of deliver	ery Day Year
1	rds, P	wrequires that been signed b should be deta	ed by Pł	Part II. Other significant conditions cont	tributing to death but not res	ulting in the underlyin	g cause given in Part I.		d tobacco use		he cause of death?
2	Division of Vital Records,	6 la hes 16 2	Completed		·			pe	as an 2 topsy formed?	24b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
1	Vita	yelclan: In is certificete director, pag	Be	25. Was case referred to medical examiner?	accitati			Death (Check on)		10.100	
0	o	rnys rthis raldir	2	1 Yes 2 No		ER/Outpatient 3 28b. Time of		g Home 5 ☐ Re	sidence 6 [		у)
ò	ion	death. ctor: After y the funer	atlor	Natural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		a non injuly o	ocumba	
skayao 10	Divis	To the Hospital of Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	<b>(y</b> )		City or 1	fown, State)		al Route Number,
2	:	24 hou 24 hou 6 Fune etely fi	edical	29a. Certifier t√ Certifyin Physic (Check only one) 2 Medical Examination	er: On the basis of examina and manner stated.	owledge, death codurration and/or investigat	ed at the time, date and pl ion, in my opinion, death o	ace, and due to the courred at the time	e, date and pla	d manner as s ace, and due to	tated. the cause(s)
	;	Within To the comp	Me	29b. Signature and title of certifier	22 222		29c. License number			igned (Month,	•
		10	1	30. Name and address of person who con	"I culture to consend the	7 220) (Tura Dilari	D36663		1 les	~ 25	,5000
		Y		30. Name and address of person who con	G con T	ranklin S	Square Dr	ive Ba	Himor	e.M	1).21237
		Sta Registr		APR 0 4 2006	Berein H	Sparke	*				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item# 8,17,18 perFH. Inf. (854-4/7/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** STRECKER 02-13 A M 30 MAR 2006 KUSSELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE, MLD

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5/27/1942 9. Birthplace (State or Foreign Month, Day, Year)

Month, Day, Year | MD CENTER MERCY MEDICAL 6. Sex 1 M 2 ☐ F Social Security Number 7. Age (In yrs. last birthday) **Funeral** 63 05/28/1942 MD 219-42-5259 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County worde r than "natural", or Iteme 23a or 28a-f ebov the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21286 United States 8301B Loch Raven Boulevard death 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Draftsman other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, 900.6 17. Father's Name (First, Middle, Last) Unknown Tinsley Lilly Tinsley Unknown Streeker Russel Theodore Strecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Gail Strecker/Wife 8301B Loch Raven Boulevard Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Apr 1 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory Inc. 2006 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives DEPOOM will 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) MUL **Physician** HOURS -TISYSTEM ORGAN /Medical Due to (or as a consequence of) Examiner SEPTIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year detached for 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed l d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably ISCHEMIC Completed RESPIRATORY CHRONIC 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 12 No certificate 1 Yes Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ves 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Attending Natural 5 Pending 1 Yes 2 No death. investigation 2 Accident after death after death Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier KRObolakia MD D0063326 MAR 30 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICAL CENTER BALTIMORE, MD KUSH. DHOLAKIA, MD MERLY 32. Registrar's Signature 31. Date filed (Month, Bay, Year) APR 0 4 2006 State CA GEAR Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Yea **Physician** Scribner epu cca 30 4c. County of Death /Medical mark 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number Limite 8. Date of Birth (Month, Day, Year) Aucust 22, 1912 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 93 Min. 219-32-7800 Usuel Residence of Decedent 1 □ M 2 0 F Director VA with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow or other traumatic avent, the Madical Examinar must be notified at BALTIMORE 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? OAKS TRAIL U 5A "natural", or Itama 23a Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: if Itam 27 ia marked other than "natural", or Itar. any injury or other traumatic avent, the Medical Expri 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 1 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOME 651 OMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be ZTZHUGH BIRdella 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA SMITH I DAUGHTER 4306 STALER DAKS TRAZI - OWENGS MEUS, Md. 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 

Burial 2 □ Cremation 3 Removal from State 6/06 RBUTUS MEN PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BEVERLY D. CROMARTIE TUNNER SELV 21. Signature of Funeral Service Licensee CHARLES ST. - BALTO., Md. 21307 consider Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician myocard; ol /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown reral unrector: Atter this certificate has been signed by filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Winh 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsied

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 4

2006

32. Registrar's Signature

		1	For State Registrer	State of M	/laryland		artment of F tificate of		d Mental Hy	giene Reg. No. )	06	103	71
	ъ0		1. Decedent's Name (First, Middle, L	ast)					2. Date of De		Year	3. Time o	
	Physicia /Medic	al	Mary L Stokes						April			9:30	AM
	Examin		4a. Facility Name (If not institution, g Crofton Convales	cent /Reha	ab Cen			Crofton		Ann	e Arunc		
	Funeral Director		214-24-4439	Sex 1□M 2DF	Age (In yrs. Ia	3 Yrs.	If Under 1 Year Months Days	If Under 24 I	Hrs. 8. Date of Bir Min. (Month, Da Jun 14	th iy, Year) 1912	9. Birthi Cou Mary I	place (State ntry) and	or Foreign
	pur *	-	Usual Residence of Decedent  10a, State 10b, County		10c. City	Town or Lo	cation					10d. Inside C	City Limits
	Aaryli f sho	ō	MD Anne An	rundel	Gaml	orills	,					1 ☐ Yes	s 2 No
	the A	ect	10e. Street and Number				10f. Zip Code			10g. Citizer	n of What Cou	ntry?	
	3e or	Ē	1706 Bargers Roa	d			21054			Unite	d State	es	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or Items 23e or 28e-f show empty injury or other treumetic event. Its Medical Examinat roust to incline a sonce.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  Widowed 4 Divorced	12. Was Deceder Armed Force: 1  Yes 25 If Yes, Give Year or Dates	s? No	1	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)		Race - Amen Black, White, Pecific k		
Maryland 21215-0036	within 72 ho ine. iben "netur iv Medical I	mpieted	15. Decedent's (Specify only highest statementary/Secondary (0-12)	Education grade completed) College (1-40	or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of	working	16b. Kind Healt	of Business/Ir :h Care	ndustry /Medic	al
and 2	d be filed v ental Hygie ced other t c event, th	Be	17. Father's Name (First, Middle, La John Howard	st)				18. Mother's Annie	Name (First, Middle Edwards	, Maiden Su	ımame)		
Mary	nd 2 shoul Ith and Me 27 is mark r treumeti	2	19a. Informant's Name/Relationship Rita Wilson/ Sis						or Aural Aoute Numb ambrills,			p Code)	
Baltimore,	Pages 1 arent of Hea		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe		te Ce	metery, crei	sition (Name of matory or other pla amily Cer		Apr 7 2006		tion - City or T		
Baltii	permit. P Departmenter Importer eny injue		21. Signature d'unitro Service Lic		7	2	Name and Addre Miller S 1922 Fore	Metropest Dri	olitan Ch ve Annap	apel olis,	MD		
	Physician		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each	n line.	tica						Approximation Interval Be Onset and	etween d Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):	13. 1	001/	20. 1.		- 0 1		
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8760,	cate be executed physician and the burial-transit	dicai Exan	that initiated events resulting in death) Last	cDue to (or	as a consequ	uence of):							
.O. Box 687	ath certifi attending for use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		a 2 ☐ Fetal t at time of de	death 3[	□Ectopic pregnanc □ Other (specify) _	у	Tables	23	d. Date of delin	very Day	Year
<u>α</u>	uires that the de signed by the a id be detached to	b	Part II. Other significant condition	s contributing to deat	h but not resi	ulting in the t	underlying cause g	ven in Part I.		tobacco use	o contribute to	the cause of	
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ita		BeC	25. Was case referred to medical examiner?						f Death (Check only	one)			
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	ding P	on:	27. Manner of Death 1 Selatural 5 ☐ Pending		Day Year)	28b. Time of Injury	We	uryau ork? ]Yes 2.∐No	28d. Describe	i now injury	occurred		
Division	or Attendition fiter death	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of	f Injury - At ho , etc. <i>(Specif</i>	ome, farm, si	treet, factory, office		28f. Location	(Street and own, State)	Number or Au	ral Route Nu	ımber,
1	To the Hospitel within 24 hours a To the Funerel Completely filled	Medicai Ce	29a. Certifier 15 Certifying (Check only one) 2 Medical E	Physician: To the be xeminer: On the basi and manner	is of examina	wledge, dea tion and/or i	th occurred at the nivestigation, in my	ime, date and popinion, death	place, and due to the	e cause(s) a e, date and p	nd manner as place, and due	stated. to the cause	ə(s)
	o the o the omple	Me	29b. Signature and title of certifier					ise number	-	29d. Date	signed (Month	n, Day, Year,	)
	FSFÖ		Kull	and	0	V	D 2	-010	8	4	13/06		
	\		30. Name and address of person w	no completed cause	of death (Item	n 23a) (Type	Print)	2 B	DOWIE, A	ND a	20713		
	St Regist	ate trar	31. Date filed (Month, Day, Year) APR 0 4 2	005 2. Reg	gistrar's Sign	Iture	use)						

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2006 Month **Physician** DOROTHY G. SPENCER March 31, 5:00pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 03/12/1915 9. Birthplace (State or Foreign Country) NEW JERSEY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 144-09-8877 91 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28e-f show other traumatic event, the Medical Examiner must be notified at Director MD BALTIMORE TOWSON 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1055 WEST JOPPA RD USA 21204 by Funerai 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12YRS HOMEMAKER HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F is marked of SAMUEL G. GARNER FRIEDA SNYDER ည Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS SPENCER(SON) 18404 GRAYSTONE RD. WHITE HALL, MD. 21161. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ō **1** 5 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if any injury or once. CARROLL CREMATION 04/04/2006 HAMPSTEAD, MD. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SONS CO. HENRY W. JENKINS & SONS C 16924 YORK RD MONKTON, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause as each line. Immediate Cause (Final disease or condition resulting in death) houmini **Physician** dans /Medical Due to (or as a consequence of): **Examiner** Obsmite Pilmoney Proude Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed 10/10/10 burial-tran Due to (or as a consequence of): Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 25 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy 2000 1 Yes 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Department 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending 1 Natural 5 Pending hours after death. uneral Director: A 2 Accident 1 Tyes 2 TNo investigation 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗋 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature 29c. License number 2 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

21215-0036

Baltimore, Maryland

P.O. Box 68760,

Division of Vital Records,

30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)

31. Date liled (Month, Day, Year)

APR 0 4 2006

			For State Registrar	State	of Marylar		artment rtificate			and M	•	giene.	]6	037	3
	nysicia	in	1. Decedent's Name (First, Middle Delcie Spur								2. Date of De Month March	Day 25 . 20	Year	3. Time of 4:50	Death pM
	Medic xamin		4a. Facility Name (If not institution		umber)		4b. City,	Town, or	Location of	of Death	March		inty of Death		
			2748 Daisy A	7e					e Hi	-			ltimor		
	neral ector		5. Social Security Number 216-42-4440	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 59	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 6 / 29 /	th ly, Year) 1946	9. Birth Cou Mary	place (State o intry) 11and	r Foreign
and	***		Usuat Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside Ci	ty Limits
Mary	I led	tor	MD Balt:	imoreaCou	nty Bal	Ltimore	High	1and	ls					1 🗌 Yes	2 🔯 No
h the	T S	irec	10e. Street and Number				10f. Zip	Code				10g. Citizen	of What Cou	intry?	
oth with	dia	alD	2748 Daisy Ave	2				227					d Stat	es	
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Z I 3-UUSO thin 72 hours aff e.	COLE		15. Deceder	t's Education		16a. Dece	dent's Usua	ıl Occupa	ation			16b. Kind o	of Business/Ir	ndustry	
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A led wi	d, the			2+		Couns	selor		10.11.1		·5		al Ser	vices	
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hould d Mer	matic	ပ္	William Frede  19a. Informant's Name/Relations		ry	19h Mailir	na Address	(Street a			atherin			n Code)	
Man (th an (	tre		John T. Spurri	40	and		•				ore Hig				21227
ages 1 ar	y or other		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Qonation 5 ☒ Other (S	3 □Removal from	n State	Place of Dispo cemetery, crer	sition (Nam natory or o	ne of ther place	e)		Date	20c. Locati	on - City or T	own, State	
mit. Pages partment of	injur		21. Signature of Funeral Service	1	) ( )		2. Name an				brose 1			Maryl	
	48		tomie (10)	Dayah	out	2	719 на	ammo	nds F		Rd Lai				Suowii
	建工		23a. Part1. Enter the disea e, o shock, or heart failure. List	complication that	caused he dea	th. Do not ent	er the mode	e of dying	g, such as	cardiac	or respiratory a	rrest,	3 113	Approximat Interval Bet	e ween
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/Med	dical		resulting in death)		o (or as a consec			100			3				
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OT VITA Physicien:	direc	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DO	A Othe			me 5 ☑ Resi	_	Other (Spec	ify)	
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DIVISION  or Attending  efter death.  Director: After	in by	Certificati	4 Homicide determ	singer   286, Plat	ce of Injury - At h ding, etc. (Speci	iome, farm, str fy)	eet, factory	r, office			28f. Location ( City or To	Street and Ni wn, State)	umber or Rui	rai Route Num	:ber,
DIVISIC  To the Hospitel or Attency within 24 hours efter death	completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ng Physician: To the	he best of my knobasis of examination	owledge, deat ation and/or in	h occurred vestigation,	at the tim	ne, date an pinion, dea	d place, th occur	and due to the red at the time,	cause(s) and date and pla	d manner as	stated. to the cause(s	;)
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6	0		30. Name and address of person	who completed ca		m 23a) (Type,	Print) Main	len	Cha	ice	Lane	& Bo	acrom	1212	28
200	Sta	_	31. Date filed (Month, Day, Year		Registrar's Sign		and B		_, 0			/	-		
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			For State Registrer	_	-	f Marylai	nd / Depa		t of H	ealth a	and M	ental Hy	giene	51e. 5	10374
			Decedent's Name (First, Midd	e, Last)								2. Date of Dea	ath	Year	3. Time of Death
	Physici /Medi		Joseph Edward	Sha	ffer							April	1, 2006	Tear	4 A M
	Examir	16	4a. Facility Name (If not institution			mber)				Location	of Death		4c. County		
			425 W. 24th		et				1tim		A		N/A		
	Funeral		5. Social Security Number	6. Sex	M 2□F		. last birthday) Yrs.	If Under Months	Days :	If Under Hours	Min.	8. Date of Birt (Month, Da			place (State or Foreign ntry)
	Director		218-05-2660 Usual Residence of Decedent			89		l				Jan. 29	9, 1917	Mar	yland
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anc		Be	Edward Shaffe									Goldsbo		θ)	
Maryland 21215-0036	s 1 and 2 should be filed within 72 ho Health and Mental Hygiene. Itan 27 is marked othar than "natur othar traumatic avant, The Medical	٤	19a. Informant's Name/Relation	hip (Type	e. Print)		19b. Maili	na Address	(Street a				er, City or Town,	State, Zij	p Code)
Z	nd 2 s lith ar 27 is r trau		Shirley Lovill		ughte	r		•					imore,		•
re,	s 1 al f Hea itam otha		20a. Method of Disposition				Place of Dispo	sition /Nan	ne of			ate	20c. Location -		
E	Page nent o int: If iry or		1 ☐ Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (3	3 ⊟Re Specify)	moval from	State Ba	ltimor				4/6/	06	Baltimo	re,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar trau <u>once</u> .		21. Signature of Funeral Service	<i>( ) (</i>	1/0	NSS		Burge	TT		T	Funera	al Home,	Inc	. 21211
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	e be executed /sician and e burial-transit	xar	that initiated events resulting in death) Last	c.	Due to	(or as a conse	quence of):								
760,	w - w	call		d.											
68	Attanding Physician: The law requires that the death certificate be e. death. etc. of the certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the buriar	Medi	IF FOLIA S									1.10			
Box	th cert tendin r use	by Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23		tcome of pregr pirth 2 ☐ Fet		Ectopic pr	egnancy				23d. Dat		ery Day Year
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tal	ician: Th certificate rector, pag	a	25. Was case referred to medical	ı						26 Plac	e of Death	1 ☐ Yes		Yes	21/2 No
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Division of	or Att	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	nined	28e. Place buildi	of Injury - At I ing, etc. <i>(Sp</i> ec	home, farm, st sify)	eet, factory	, office		2	:8f. Location (S City or Tox	Street and Numb vn, State)	er or Run	al Route Number,
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	1		30 Name and address of person	who con	npleted caus	se of death (Ht	im 23a) (Type,	Print)		11 .		-	4.1		2
9	4		16 whatel		1am	on	37	30	t-u	1/5	154	15	29d. Date signed	McC	21211
	St Regist	ate	31. Date filed (Month, Day, Year		32. F	tagistrar's Sign	nature	Carte							
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Sarah Jane Sheets 06-02224 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27 28a-f privilery tand / Department of Health and Mental Hygiene crn 1 = For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SHELTE SARAH 2006 JANE March 31 12:51 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** 1 M 2 F Director 79 219 04 8501 NOV-11, 1983 JARAMANO Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Modical Examinar must be notified at 1 ☐ Yes 2 No Directo ( Barreno HARFORL ABIR OSIN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With -- snould be filed within 72 hours after death with and Mental Hygiene.
7 is marked other ther "-- "aurmai". KOAN Funeral 3908 31001 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Never Married 2 ☐ Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Yes, Give Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 127KS. HOWEMOKER permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked othe any injury or other traumatic avent, odg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NAMEY MAZ LAMPBELL Ozrwza TIZZHZ ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 20c. Location - City or Town, State 545255 BETTEO DELTRE 10212512512 BOLE CIARMAN KOGO Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition HORIL 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) AIRIZM GAROUN SUPLLE 2000 21. Signature of Funeral Service License 22. Name and Address of Facility CHAPIL—BILAIN
EVAN FUNCTOUR DRIVE FOREST HILL -BZIRIR, P.A. BIOST May MANDAMO Nagar 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Methadone intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 yes 2 No

9 Unknown Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à certificate has been si rector, page 2 should t 1 ☐ Yes 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed: 2 🗆 No or Attending Physicien: 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 ER/Outpatient 3 □ DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) ≸☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☑ No 2 Accident Fnd 3/31/2006 Fnd 12:035 hours after death uneral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4309 Pillaski Hwy. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide Fnd: private dwelling within 24 hours a

To the Funeral C

completely filled Hospitel Belcamp,MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. April 01, 2006 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRELL 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month De 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2006

SHIELEY SULLIUM)

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			For State Registrar	State of Maryland /	Department of Health and N Certificate of Death	nentai Hygien Reg. N	ZHIB THRIN
			1. Decedent's Name (First, Middle, Last)	_		2. Date of Death Month D	ay Year 3. Time of Death
и	Physici /Medic		SHIRLEY R.	SULLIVAN		MARCH =	
	Examin		4a. Facility Name (If not institution, give st	treet and number)	4b. City, Town, or Location of Death	4	c. County of Death
			LORIEN (a) KIL	ERSIDE	BEMAMO		HARFORD
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
	Director		318 37 03 64	112	Yrs.	JANUARY 4	WHI LICHIGAN
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tox	wn or Location		10d. Inside City Limits
	f sho	5	1000 1000 NOOTO	0 6.5	RiR		1 □ Yes 2 No
	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show iteal Examinat must be multifud at	Funeral Director	10e. Street and Number	(7)	10f. Zip Code	10g. C	Citizen of What Country?
	with Sa or	0	1308 LHRETOPH	ea Pour	21014		A 2.5
	ns 20	era		2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - American Indian,
(0	riter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 25 No	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.
215-0036	172 hours after dea "naturel", or Items aftest Examiner m	by	3- Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 25 No Specify:		Specify: BLACK
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21	within 7 ene. then "r	ple	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)		_
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nd	be file d oth even	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maide	
Maryland	Men Men arka atic	2	UBAMAN HZ	noisson, IT	The state of the s	MXZLA A	
ar	2 sho and is ma		19a. Informant's Name/Relationship (Typ		b. Mailing Address (Street and Number or Ru	ral Route Number, City	- Manh
	1 and Health tem 27		Pere 1 167 - 11 - 007 1 - 1 - 1 - 0 - 0 - 1	/ALL 130h Blace	of Biographica (Name of	Date 20c.	Location - City or Town, State
ore	of H of H If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	of Disposition (Name of ery, crematory or other place)	17.3	Location City of Town, State
Ë	Pag ment ent:		`4 ☐ Donation 5 ☐ Other (Specify)	V - 12	THIN 12 30	op to	
Baltimore	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		21. Signature of Funeral Service License		22. Name and Address of Facility		LAIRIRA
_	<u>v</u> ∪ = e d		hear As we		3 UEMBORT DRIVE	FORESTH'S	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	callions that caused the death. Do	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
4	Physician	Ų.	Immediate Cause (Final disease or condition	Aspiration	n Pheumonia		Few days
	/Medical Examiner		resulting in death)	Due to (d) as a consequence	of):		1
п	Examine	V_1	Sequentially liet conditions, b	Orophar	ynaer Wish	ROIA	
. )	P #	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a a consequent	( )	,	
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687	hysic the t	dica	d	l			
9 x	eath certificate be execut attending physician and for use as the burial-trar	Physician/Medical	IF FEMALE:	3c. If yes, outcome of pregnancy			23d. Date of delivery
Box	death c e attended for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetal dea 4 Pregnant at time of death	th 3 Ectopic pregnancy 5 Other (specify)		Month Day Year
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ds,	= 0, 0	d by	Coraband	1-0-1	X and	1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	v requir been si should	Completed by	Cevenrov	ascular	recident	24a. Was an	24b. Were autopsy findings available
3ec	as as	ldm				autopsy performed	prior to completion of cause of death?
3 5	: The cate h					1 Yes 2 1	1 Yes 2 2 46
Division of Vital Records,	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Other	(Check only one)	C DOMES (Const.)
of	Phys this ral di	. To	1 Yes 2 No 27. Manper of Death	1 Inpatient 2 EHV	Dutpatient 3 DOA 4 Drusing P	lome 5 Residence 28d. Describe how in	
u	ding Phys h. After this funeral di	lo	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No		
Sic	death ctor: /	ica	3 Suicide 6 Could not be	28e Place of Injury - At home.		28f. Location (Street	and Number or Rural Route Number,
Ì	or A after Direction by	Certification:	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	,,,	City or Town, Sta	ate)
_	Hospitel 24 hours a Funerel tely filled	0	29a. Certifier 1 Certifying Phys	sician: To the best of my knowled	ge, death occurred at the time, date and place	, and due to the cause	(s) and manner as stated.
	24 h 24 h Fur etely	edical	(Check only 2 Medical Examination)	ner: On the basis of examination and manner stated.	and/or investigation, in my opinion, death occu	irred at the time, date a	and place, and due to the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	1	29c. License number	29d. [	Date signed (Month, Day, Year)
	F > F 0		) M	VMIK)	DIGHE	3 A	pril 2, 2606
	1		30. Name and address of person who co	omphaed as of salh (Item 23a	a) (Type, Pri	Strant	- 16000
	V \	1	Manual M.	Loss.	MD Suy	hiland	1 Trevaler
	St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	100	Tona	
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DI	IMH 17 Rev 1/2	2001					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** March 2006 Lawrence Maltier Sellers, Jr. :30 7 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AIR HEALTH AND REHABILITATIN CENTER IARFOR! Social Security Number Birthplace (State or Foreign Country) **Funeral** Hours Min Months Days Director 219-38-5117 23, 1940 Maryland 65 Auq. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County worle er than "natural", or itams 23a or 28a-f ahov the Medical Exeminar must be nutified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 299 Wakely Terrace USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 3 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 12 Truck Driver Beer Distributor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Lawrence Maltier Sellers, Sr. Rose (nmn) Pennington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar important: if item 27 is any injury or other trau once. Virginia Ann Sellers / Wife 299 Wakely Terrace, Bel Air, MD 21014 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐Donation \_ 5 ☐ Other (Specify) Mountain Christian Cem. 3-31-06 Joppa, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 21. Sig/ture Juneral Prvice Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications hat crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** En anuera /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be executed and burial-tran Due to (or as a consequence of) 68760. the attending physicien Physician/Medical death certificate use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached o 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, should be 1 Yes 2 No 3 Probably 4 Nonknown Completed peen . Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy certificete 2 🗆 No 1 🗌 Yes 202 No 1 🗆 Yes a 25. Was case referred to medical examiner? director Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ 1 Inpatient 2 2 ER/Outpatient 3□ DOA this o funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? Certification: After 1 Natural or Attending Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eta 31. Date filed (Month, Day, Year, 32. Registrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SONDERMAN NELLIE Κ. 9:50 P. M MARCH žÿ, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GLEN MEADOWS GLEN ARM BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1 □ M **X** X F Hours 03-15-1913 216-01-6937 93 MARYLAND Director Vrs Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Item 27 is marked other then "natural", or items 23a or 28a-f show other traumatic event, it a M. ofcal Examinal mast be notified at MD. BALTIMORE GLEN ARM Director 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 11630 GLEN ARM ROAD 21057 U. S. A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ XNo If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No WHITE 2 Specify XX Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72.1 Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natt any niury or other traumatic event, Ite M. dical 2006. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) EQUITABLE LIFE Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+) SECRETARY ASSURANCE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELMER KUNKFL BESSIE WRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR W. SONDERMAN, JR. (SON) 10015 NEARBROOK LANE, PARKVILLE, MARYLAND, 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

XXX Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 04-03-2006 TIMONIUM, MARYLAND, 21093 DULANEY VALLEY M.G. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 Y Kuin (R.G.RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician EMENTIA disease or condition resulting in death) 64 EHRS /Medical Due to (or as a consequence of): Examiner HEROSCLE ROSIS Equaritiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed PERLIPI DEMIA Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2XXNo Day 4☐Pregnant at time of death Month Year 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ۾ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by RIENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an has performed? certificate 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: XX Nursing Home 5 Residence 6 Other (Specify) 일 1 ☐ Yes XX No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After XXNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a XX Certifying Physician: To the best of my knowledge, death conumed at the take, date and place, and due to the cause(s) and manner as stated.

2 Martical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 24 ho To the Func (Check only one) 29b. Signature and title of centrier 29c. License number 29d. Date signed (Month, Day, Year) RAMANA horacki M. D MARCH 31, 2006 Name and address of person who completed cause of death (Item )a) (Type, Print) 2 (ROSPROAD) RAMANA MD 21228 31. Date filed (Month, Day, Year) 32) Registrar's Signalure State Registrar

	1 = For State Registrar	State of Maryland /	Department of Health and Note of Certificate of Death	Mental Hygier Reg. h	-000 10010
Physician	1 Decident's Name (First, Middle, L	Sends		2. Date of Death	Oay 2006 9: 20 A M
/Medical Examiner		ive street and number)	4b. City, Town, or Location of Death	- U- U-	4c. County of Death
	5. Social Security Number 6.	Sex 7. Age (In yrs. last	birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Baltimore  9 Rithplace (State of Foreign
Funeral Director	214-68-3495	1□ M 2 X F 5/	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, You	9. Birthplace (State or Foreign Country)
laryland	Usual Residence of Decedent  10a. State 10b. County	100 Cit), To	own or Location		10d. Inside City Limits
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23a or 2	7-469 Kalton	Court	10f. Zip Code 2/208	Tog. C	Citizen of What Country?
3 · 30 · 0 6 9 ° 20 ° 0 ° 12 ° 20 ° 0 ° 12 ° 20 ° 0 ° 21 ° 21	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	If Yes, Give	13. Was Decedent of Hispanic Origin? (Sinf Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
30.0 15-0036 172 hours att		Year or Dates:  Education 16	6a. Decedent's Usual Occupation (Give kind of work done during most of work	king 16b.	Kind of Business/Industry
d 21215-00 d 21215-01 filed within 72 hou Hygiene. Other than "nature and, the Madical and, the Madical ed.	Elementary/Secondary (0-12)	Collège (1-4or 5+)	(Give kind of work done during most of work life. FONGT use retired)	J	nsurance
ryland 212 ryland 212 hould be filed wilt d Mental Hygiene marked other tha marked sovent, Ital	17. Father's Name (First, Middle, Las			ne (First, Middle, Maid	
Marylanc de should be the and Mental the and Mental to the analyse of traumatic even	191. Informant's Narra/Relationship	(Type, Print)	9b. Mailing Address (Street and Number or 40	r I Route Number, City	y or Town, State, Zip Code)
SI-IT-RON ore, Marylan os 1 and 2 should be of Health and Mental Item 27 is marked or other traumatic ever	Charles R. Sano	ls, Sr. /Husband 7	469 Kalton Ct. Ti	lasville, a	mD 21208
	20a. Method of Disposition  1 ABurial 2 Cremation 3 4 Donation 5 Other (Spec	sify) Bus	n of Disposition (Name of tery, crematory or other place)  hy fark	5-06 Co	Location - City or Town, State
Baltimo Permit. Page Department Important: Il any Injury of ones.	21. Sign tun of Funeral Pervice Lice	nsee Seese	7728 Libert Rd	Randal	Ustauns, MD 2433
9	shock, or heart failure. List onl	nplications that caused the death. D	o not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)	a. Mutas tahir  Due to (or as a consequence	brust cancer		martis
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vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed redeath.  Total the certificate has been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit filtration: To Be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 prioriths? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23d. Date of delivery Month Day Year
Division of Vital Records, P.O or Attending Physician: The law requires that the after death. In plirector: After this certificate has been signed by the in by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached the funeral director.	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
If Records, The law requires 1 ase has been signe page 2 should be.				24a. Was an	24b. Were autopsy findings available
Vital Receition: The law certificate has irrector, page 2				autopsy performed? 1 Yes 2 1	
of Vita Physician: This certific ral director.	examiner?	Hospital: 1 Inpatient 2 ER/	0.0	th (Check only one)	6 Dother (Specify) NUSPIG
On of ding Phy After this funeral c	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b	p. Time of 28c. Injury at Nork?	28d. Describe how in	
VISIO Attendi r death. ector: A by the fu	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of Injury - At home,	M 1 ☐ Yes 2 ☐ No farm, street, factory, office	28f. Location (Street	and Number or Rural Route Number,
Divelor urs afte or urs afte or urs afte or urs afte or urs after or u	4   Homelde	building, etc. (Specify)		City or Town, Sta	
Division C To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After t completely filled in by the funeral Medical Certification:	29a. Certifier 1 Certifying F (Check only 2 Medical Exe	Physician: To the best of my knowled eminer: On the basis of examination and manner stated.	dge, death occurred at the time, date and place and/or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as stated.  Indicate, and due to the cause(s)
To the within 2 To the complet	29b. Signature and little of certifier	1 1 1	29c. License number	29d. [	Date signed (Month, Day, Year)
20		o completed cause of death (Item 23;	and/or investigation, in my opinion, death occu  29c. License number  D S 8 30 3  a) (Type, Print)  N WWW ST B	> //	10.0.31251
<b>♂</b> State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	N. Charles ST B	rome	VWI CIWY
Registrar	APR 0 4	2006	( Species		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 19a per fh 9854 4-4-06 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL 1, <sup>Da</sup>Ž006 **Physician SHRUBSTOK** ILYA 8:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE GILCHRIST CTR TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth APR. 18, 1938 9. Birthplace (State or Foreign Country) KRAINE **Funeral** 1 M M 2 □ F 217-25-9986 67 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'naturel', or iteme 23a or 28a-f ehow Funeral Director MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 STONEHENGE CIRCLE #12 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 ☑ No Specify: ģ WHITE 3 Widowed 4 Divorced Baltimore, Maryland 21215-003 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Importent: if item 27 is marked other then 's night yor other treumatic event, the Me ponce. Etementary/Secondary (0-12) College (1-4or 5+) GEOLOGIST GEOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( SHRUBSTOK ဂ GRIGORY ANNA BURSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Infadelya «Bikiflowskaya ADA SHRUBSTOK / 5 STONEHENGE CIRCLE #12 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HAR SINAI CEMETERY 04/03/2006 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician pancreatic cancer months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical ettending properties of the pr IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificete has birector, page 2 s Hospitei or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 AQther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 1 ☐ Yes 2 ☑ No hospico Director: After th 28c. tnjury at Work? 27. Manner of Death 28a. Date of tnjury (Month, Day Year) Medical Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 | Homicide within 24 hours aft To the Funeral Di completely filled in McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the F 29b. Signature and titte of certifie 29c. License number 29d. Date signed (Month, Day, Year) Gp. 2006 000519260 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. 4 Charles Bultimas MD Gurdan 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar APR 0 4 2006

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State of Maryland / Department of Health and Mental Hygiene  Certificate of Death	Reg. No.	2006
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Physici /Medio		Decedent's Name (First, Middle, Last)     Ruth	E.			rner		2. Date of De Month April	3, 2	2006	3. Time of Death 5:05 P
Examir Funeral Director	er	4a. Facility Name (If not institution, give s  1640 Manor Road  5. Social Security Number  215-09-1647		st birthday) Yrs.	4b. City,  If Under		der 24 Hrs.	8. Date of Bir (Month, Da May 16	th ay, Year)	Baltimor  9. Birth Cou Vir	
D	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		Town or Lo							10d. Inside City Lim 1 ☐ Yes 2页1
h with th	Funeral Director	10e. Street and Number 1640 Manor Road			10f. Zip	21222			_	tizen of What Cou SA	intry?
/2 nouts after death with the Marylan fratural, or items 23s or 28s-1 chow digal Exama at mather profitted at		11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		Was Deced If Yes, spe-	dent of Hispanic offy Cuban, Mex 2 No Spec		ecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White Specify: Wh.	
then then	Completed by	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8 years	cation e completed) College (1-4or 5+)	(Give life.	dent's Usu kind of wo DO NOT u	al Occupation ork done during rise retired)	nost of work	ing	16b. K	Kind of Business/Ir Steel	ndustry
	To Be C	17. Father's Name (First, Middle, Last)  John Walter Reynol				18. Mai	cy Ell	en Gild	len		- C- 1-1
127 = 12		19a. Informant's Name/Relationship (Ty Kimmerly Kaminski	great niece	1642	Mano	r Road,	Dunda	lk, Mar	ylaı	or Town, State, Zind 21222	
nent of ant: If it ary or c		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Ho1.		natory or o	norial	-	1°7 <b>,</b> 006		ocation - City or I	
Departr Importe eny inje		21. Signature of Funeral Service License	Connel	ly :	Corine. 7110		eral U Point			dalk,P.A dalk,Md.	21222 Approximate
hysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List of the following shock of the failure of	Dementa								Interval Between Onset and Death
physician and s the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to minufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause.								
ate has been signed by the attending phy page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	∃Ectopic p ∃ Other (sp					23d. Date of deliving Month	very Day Year
been signed b should be deta	ρ	Part II. Other significant conditions con	ntributing to death but not resul	lting in the u	inderlying o	cause given in Pa	art I.	1			the cause of death bably 4 ⊟Unkn
	Completed							1 Yes	psy ormed? 2 No	prior to co	opsy findings avail ompletion of cause 2 No
r this certific	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1   Inpatient 2   E	R/Outpatier	nt 3 D	Other	Nursing Ho	me 5 Res		6 ☐Other (Spec	ıfy)
	Certification: 7	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	28b. Time o Injury	М	28c, Injury at Work? 1 ☐ Yes 2	2 □No	28d. Describe			
Funeral Director: After the fune filled in by the fune		4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify, sicien: To the best of my know	)				City or To	wn, Stat	9)	ral Route Number,
within 24 hours a To the Funeral I completely filled	Medical		ner: On the basis of examinati and manner stated.								
within 2 To the	W	29b. Signature and title of certifier  Sati Jan	.)—			C. License numb			. /	ate signed (Month	, Day, Year)
1		30. Name and address of person who co	2112 Dundal	KA	Print)	Baltin	we ,	MB :	512	22	
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signati	ure .	الم						

			1 - For State Registrar	State of M	aryland	-	artment rtificate			nd Menta		ene	06	10383
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)	Th	200	+01		Co.	Mo	e of Death	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gi	Ve street and number)		013			Location of	7,00	irch	<b>25</b>	ZOOO Inty of Death	12/5 4 1
1	⊫xamii	er	HARBOR	HOSPITA	46		31		nmo			70, 000	my or boam	,
	Funeral Director		114-54-5564	Sex 7. Ag 1 M 2 F	19 (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours		e of Birth nth Day, 28, 1	932	9. Birth	nplace (State or Foreign untry), and
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	• Mary e-f sh	ctor	MD Anne Art	unde1	Linth	icum								1 ☐ Yes 2 🙀 No
	vith the	Director	10e. Street and Number				10f. Zip						of What Cou	intry?
	leath v	erai	4040 Catherine A	12. Was Decedent	Ever in U.S.	. 13.	2109 Was Deced	lent of Hi	ispanic Origi	in? (Specify Ye	s or No-	S.A.	Race - Ameri	ican Indian.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If itam 27 is marked other than "netural", or Items 23a or 28e-f show or other traumatic avant, the Medical Examinat must be rediffed at	by Funeral	1 ☐ Never Married 2√2 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	•		fYes, spec 1⊡Yes 2	ify Cuba	n, Mexican, Specify:	Puerto Rican, e	etc.)	E	Black, White, acify:Whit	, etc.
5-0	72 hc "netur	eted	15. Decedent's E (Specify onfy highest g	ducation rade completed)		16a. Dece (Give	dent's Usua kind of wor	l Occupa	ation during most	of working	16	6b. Kind o	f Business/Ir	ndustry
12	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Maker		)		C	)wn H	ome	
<b>d</b> 2	e filed Il Hygid other vant, Il	Be C	17. Father's Name (First, Middle, Las						18. Mother	's Name (First,	Middle, Ma	uiden Surr	name)	
Maryland	2 should be and Mental is marked o	To	Ingimundur Gudmu						Gudmu	ında Eir	iksdo	ttir		
Mar	d 2 sh th and 7 is m traum		19a. Informant's Name/Relationship				_			r or Rural Route				p Code)
	s 1 and 3 f Health itam 27 other tr		Halldor Thorstein  20a. Method of Disposition	nsson/ Husi	20b. Plac	ce of Dispo	sition (Nam	ne of		ie Linth Date			n - City or T	own, State
mo	T P P		1 ☐ Burial 2 XX remation 3 (				natory`or of ide1 C			3-27-20	06 Od	lento	n, MD	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If itam any injury or othe		21. lignature of Funeral Service Lice	origon VOILO	WA.	Am 27	Name and brose 19 Ha	d Addres Fur mmor	s of Facility neral nds Fe	Home of	Lans Lans	down down	e e MD 2	21227
			23a. Part1. Enter the disease, or cor shock, or heart failure. List on	mplications that caused y one cause on each li	d the death. ne.							t,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		VOX	lc	ENC	EN	HALL	PATO	14			Onset and Death  O  D  Y  .
Û	Examiner			Due to (or as	a conseque	nce of):	nn	pn	KIN	UDDIA	<b>_</b>			
	p .=	ner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  a.   ANOXIC ENCEPHALOPATHY  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
V	and -trans	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	2.00050000	noo of):								
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9	tificate ig phys as the	ledic		d										
P.O. Box	ne death cer the attendir thed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal d	eath 3	Ectopic pre Other <i>(spe</i>						Date of deliv Month	very Day Year
Vital Records, P.	quires that the signed by all be detacted	by	Part II. Other significant conditions		ut not resulti	-	, ,	ause give	en in Part I.	236	e. Did tobae		~ /	the cause of death?
eco	law require as been si 2 should I	Completed	1+45	OThyn	DIDI	15m				248	a. Was an autopsy	24	b. Were auto	opsy findings available ompletion of cause of
<u>~</u>	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Com	/							1□	performe Yes 2	No	death? 1 ☐ Yes	
Vita	sician certifii rector	Be	25. Was case referred to medical examiner?	Hospital:				Cthe	ar:	of Death (Check				
Division of	y Phys er this eral di	7. To	1 ☐ Yes 2 D.No 27. Manner of D ath	28a. D te of Inju	iry 2	NOutpatier 8b. Time o		Bc. Injury	at Nurs	sing Home 5 [ 28d. De	☐ Resideno scribe how			fy)
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<u>ivis</u>	l or Atter after de Directo	rtific	3 Suicide 6 Could not 4 Homicide determined		ury - At hom c. (Specify)	e, farm, str	eet, factory,	, office			ation (Stree		mber or Run	ral Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying P	hysician: To the best	of my knowle	adaa daas		në ële e ëles		l place and due	to the second	/-)		
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	(Check only 2 Medical Exa	miner: On the basis o and manner st	f examination ated.	n and/or in	vestigation,	in my op	pinion, death	n occurred at the	time, date	and plac	e, and due t	to the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	)			29c.	. License	number		29d	l. Date sig	ned (Month,	Day, Year)
	100		1 W. ) for	12, M	D		1	(2:	5 00	00	N	1AR	CH Z	5,2006
	3		30. Name and address of perion who will sime was a second of the way of the w	completed cause of c	leath (Item 2 3001 ar's Signatur	(3a) (Type,	tano	ver	2 51	+, #8	5 1	Salh	more,	stated.  Lot the cause(s)  Day, Year)  S, Zoo 6  MD ZIZZS
	Sta Registr		51. Date liled (MORITI, Day, Year)	32. Hegistr	aı ə əignatui	K A	beste	,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 03 31 2006 11:30 P Christine Margaret Volz /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Parkville Baltimore Oak Crest Care Center If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 ☐ M 2 🔀 F Yrs. 05/08/1915 03/31/20c6 Director 90 Maryland 213-28-6866 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 1702 Pine Forest Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaking Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Frederick Deigert Katherine Besold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trau once. 1702 Pine Forest Court - Bel Air, Maryland Daniel R. Volz (son) 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gardens of Faith Cem. 04/05/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 16 11750 Belair Road - Kingsville, Maryland 21087 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mtr Physician /Medical Due to (or as a consequence of) Examiner ASUD Couper triany first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 20 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 27**2**1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 No 4 Hursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ 24 hours a \* Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MISTEL

State Registrar

31. Date filed (Month, Day, Year)

WILLAM



State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2006 Month Year **Physician** 11:20 PM M Earl Perc Williams 2, April /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 15435 Good Hope Rd. Montgomery Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O9/27/1919 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** M 2□F 86 285-03-4357 Yrs. OH Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after daath with the Maryland nent of Health and Mental Hygiene. Intern 27 ie marked other than "netural", or items 23s or 28s-f show 10c. City, Town or Location 10a. State 10d. Inside City Limits event, its Medical Examinar must be notified at 10b. County 1 ☐ Yes № No Director MD Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905-15435 Good Hope Rd. United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

NOTYES 2 No 1942 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: White þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Sewing Thread Co. Elementary/Secondary (0-12) College (1-4or 5+) Company Comptroller 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Cullen Williams Alice Pickersgill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Williams/Son 15435 Good Hope Rd. Silver Spring, MD 20905-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: if eny injury or once. 04-04-2006 Beltsville, Maryland Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee MOO 332 Steles Lohman 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death Months 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician Carcinoma Ureter /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): cian/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has by page 2 s 1□ Yes 2☑No certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other 4 Nursing Home 5 Na Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA his 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. filled in by the f 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 24 one) To the F 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 04-03-2006 D24997 0 30. Name and address of person who completed cause of death (Item 23a) (Type Print)
Luis A Casas 8317 Cherry Lane Laurel MD 20707

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

32 Degistrar's Signature

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#7, perFH, C854 4/7/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner timore 1 tas Age (In yrs. last birthday) 8. Date of Birth
Jan. 22,1927 5. Social Security Number Birthplace (State or Foreign **Funeral** 1**X**M 2□ F Months Days Min 220-18-5953 Hours Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Marylana more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ the Medical Examiner must be 21 238 20 Funeral 12. Was Decedent Ever in U.S. Armed Forces? or iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married ☐Yes 2 No 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Slac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene Important: If item 27 is marked other than 1 marked other than 1 may injury or other traumatic event, the Magance. Elementary/Secondary (0-12) College (1-4or 5+) d 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname Be Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship (Type, Print) (New ew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21328 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, 1 Burial 2 ☐ Cremation 3 Removal from State stern 4 ☐ Donation 5 ☐ Other (Specify) star 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between shook, or heart fail Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 40 myocardial /Medical Due to (or as a consequence of): Examiner 10 years coronory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Be Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 sl 24a. Was an autopsy performed? Yes 212 No 1 Yes Division of Vital funeral director. 25. Was case referred to medical examiner?
1 ☑ Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ٩ 1 Inpatient 3 DOA this 27. Mannal of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury death 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 173386 18 4.3.06 lunu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ecten Place Bultivore, ND 21217 Dunial Howard 1714 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

2006

			1 - For State Registrar	ate of Marylan	d / Depa		t of H	ealth a			9	6	1038	37
*	Physici	an	1. Decedent's Name (First, Middle, Last)  ANNA  V.	WATERS						<ol><li>Date of Death Month</li></ol>	Day	Year	3. Time of 09:55	
4	/Medic	cal	4a. Facility Name (If not institution, give street			4h City	Town or	Location o	of Death	04	4c Count	2006 y of Death	09.53	A M
40	Examir	ier		G REHAB		45. O.O.		OLUN			HOWARD			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 15 24 6171	7. Age (In yrs. 1	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Date of Birth (Month, Day, Jan 9,	<sup>Уөаг)</sup> 1918	Cou	place (State or ntry) Land	r Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation							10d. Inside Cit	y Limits
	Mary a-f ah	tor	MD Howard	El	licott	- Cits	7						1 🗌 Yes	2 <b>X</b> No
	or 28	Oirec	10e. Street and Number	•		10f. Zip	Code				g. Citizen of			
	ath w	rall	9828 Middle Meadow Ro		0 100						United			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show stay figury or other traumatic avent. Its Medical Examinational be notified at ance.	by Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U. med Forces? ] Yes 2 2 No /es, Give ar or Dates:	n U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☑ No Specify:					ican, etc.)		ick, White,	can Indian, etc. ack	
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Mai	th and 27 tan n		19a. Informant's Name/Relationship (Type, Pr Ava J. Baker/Daughter							Route Number,	-			2
Baltimore,	ages 1 an nt of Heal t: If Item 2		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Remove	20b. P	face of Dispo emetery, crer	sition (Nam natory or o	ne of ther place	θ)	Da	ite 2	oc. Location	- City or To	own, State	
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	Physician		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau immediate Cause (Final disease or condition	s that caused the death se on each line. S'EVERE				g, such as	cardiac or	respiratory arre	st,		Approximate Interval Betwoonset and D	reen
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<u>Б</u>	lhat the	/ Phy	9 Unknown  Part II. Other significant conditions contributi	ng to death but not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did toba	acco use con	tribute to t	he cause of de	eath?
rds	w requires been sign should be	ed by	HYPERTENSION							1 🗆 Yes	s 2□No	3 Prob	pably 4 🗹	nknown
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	To the Hospitel or J within 24 hours after To the Funerel Dire completely filled in b	edical C	29a. Certifier 1 Certifying Physician: (Check only one) 1 Medical Examiner: O ar	To the best of my known the basis of examinated manner stated.	wledge, death tion and/or in	occurred avestigation,	at the tim in my op	e, date and pinion, deat	d place, ar th occurred	nd due to the cai d at the time, da	use(s) and m te and place,	anner as s and due to	tated, the cause(s)	
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1	)		30. Name and address of person who complete 14300 Gallant Fax L	1 # 210	Bo	BIWIE	J	MD		20715				
	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 4 2006	82. Registrar's Signa	ture									

			1 - State Registrar		partment of Health and Nertificate of Death	Mental Hygier Rag. I	2000 10000
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year 3. Time of Death
	Physici /Medio		Joseph Willis Wood, Jr.			March 3	26 2006 6,10 PM
1	Examir	ier	4a. Facility Name (If not institution, give street and	number)	4b. City, Town, or Location of Death		4c. County of Death
			5. Social Security Number / 6. Sex	OSPITAL	KOSCOAIC	O Date of Birth	Dairinore
	Funeral Director		5. Social Security Number / 6. Sex 215-40-9325	7. Age (In yrs. last birthda) 59 Yrs.	Months Days Hours Min.	8. Date of Birth Month, Day, Yea April 14	9. Birthplace (State or Foreign Country) 1946 Maryland
	ט		Usual Residence of Decedent			1	
	anylar show	_	10a. State 10b. County MD Baltimore	10c. City, Town or I Middle Ri			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ecto	10e. Street and Number	ritudie Ki	10f. Zip Code	100	Citizen of What Country?
	with With	<b>Funeral Director</b>	65 B Oak Grove Drive		21220		S.A.
	laath	era	11. Marital Status 12. Was D	ecedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (So	ecify Yes or No-	14. Race - American Indian.
Maryland 21215-0036	should be filad within 72 hours aftar death with the Maryland of Mantal Hygiana. marked other than "natural; or Itema 23s or 28s-f show matic event, the Medical Examiner roust be notified at	by	1 Never Married 2 Married 1 ☐ Yes,	Forces?	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2⊠ No Specify:	Rican, etc.)	Black, White, etc.  Specify: White
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12	filad v Hygia ther t		12 2 17. Father's Name (First, Middle, Last)	Secur	ity Guard	e (First, Middle, Maid	ecurity
and	d be f antal } ted of	o Be	Joseph Willis Wood, Sr.		Anna	e (r iist, iviidale, iviala	on ourname)
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	1 and 2 Health ar tem 27 is		Linda Taylor Wood/ Wife	65 B	Oak grove Drive M	iddle Rive	er MD 21220
ore,	of Height of Height of Item		20a. Method of Disposition		ematory or other place)		Location - City or Town, State
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Baltimore,	permit. Page Dapartmant of Important: if any injury of once.		21. Signature of Funeral Service Licensee	A	22. Name and Address of Facility mbrose Funeral Hom 719 Hammonds Ferry	e, Inc.	us MD 21227
I			23a. Part1. Enter the disease, or complications the	at caused the death. Do not e	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
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/ita	Physician: 1 this cartifical ral director, p	Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
<b>6</b>	0 v 7	P	1 ☐ Yes 25 No Hospital:	✓ npatient 2 ER/Outpatie			6 ☐Other (Specify)
L C	اع اعتاد	ertification:	1 Natural 5 ☐ Pending (A	ate of Injury fonth, Day Year) 28b. Time Injury	of 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe how in	qury occurred
Division	a ta a	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Pl	ace of Injury - At home, farm, s		28f. Location (Street	and Number or Rural Route Number.
Ö	al or / s aftar ! Dire	Certi	4 Homicide determined bi	illding, etc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	City or Town, St	
	To the Hospital or Atta within 24 hours aftar da To the Funeral Directo complataly fillad in by th	edical (	(Check only 2   Madical Examiner: On the	the best of my knowledge, dea e basis of examination and/or nanner stated.	ath occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number	29d. l	Date signed (Month, Day, Year)
			TEN-CI	log Wu MD	Kes 00000		Jarch 26, 2006
	1		30. Name and address of person who completed of	ause of death (Item 23a) (Type	Print)	1 7 1/0	m. M. 010-1
9	79		31. Date flow (Month, Day, Year)	1 7000 Fran	KIN Sylvare sho	K Daltil	More, 114 2125/
	Sta Registi		APR 0 4 2006	2. Registrar's Signature	Res 00000 Ain Square Snice		
			111 11 0 2				

			Please	Type or Print in					-	_	•
			For	State of Maryla	•				Mental Hy	giene	10388
			1 - State Registrar		Ce	rtifica	ate of	Death		Reg. No:	10000
			1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea	ath Day Yea	3. Time of Death
	Physicia /Medic		JOHN T. WIL	SON					MARCH	27 2006	0357 M
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. Cit	ly, Town, o	r Location of Deat		4c. County of De	
			NORTHWEST HOS	SPITAL		RAI	NOAL	2STOWN		BALTIMOR	E COUNTY
	Funeral		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday,		der 1 Year	If Under 24 Hrs. Hours Min.	(Month, Da	h y, Year) 9. E	Birthplece (State or Foreign Country)
	Director		213-60-2114	AM 2UF	53 Yrs.			<u></u>	May 12,	1952 Ne	w York
-	2 2		Usuel Residence of Decedent  10a, State 10b, County	100	City, Town or L	ocation					10d. Inside City Limits
	aryis aho	2			.,,		Orri	ngs Mills			1 ☐ Yes 🛠 反 No
	28a-1	ect	Maryland Baltimo:	re County		106	Zip Code	igs milis		10g. Citizen of What	Country?
	Ne C	ä	20 Enchanted Hills	Road Ant 1		101. 4	zip Code	21117		TOG. CRIZOTTOS WHAT	USA
:	n /2 nours atter death with the maryland "natural", or liems 23a or 28a-f ahow edical Examiner must be notified at	by Funeral Directo	11. Marital Status	12. Was Decedent Ever in		Was Der	redent of H			- 14. Race - A	merican Indian,
	Iten Iten	'n	1 □ Never Married 2 X Married	Armed Forces?				lispanic Origin? (S an, Mexican, Puerl	to Rican, etc.)		hite, etc.
<u>ک</u> آ	nours after tural', or Ite	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>X</b> 100	Specify:		Specify:	Black
215-0036	z nou		15. Decedent's Ed		16a. Dece	edent's U	sual Occup	pation		16b. Kind of Busine	ss/Industry
2		ple	(Specify only highest gra	de completed)  College (1-4or 5+)	- (Give	DO NOT	work done use retire	during most of word)	rking		
7	filed within 72 Hygiene. Sther then "nei	Completed	12	0011090 (1 401 01)	Che	ef				Restauran	t
0		Bec	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle,	Maiden Sumame)	
<u>a</u>	lid be kental ked c	To B	John Thomas 1	Wilson, Jr.				Na	arcissus	Mitchell	
maryland	Should N		19a. Informant's Name/Relationship (7	Type, Print)	19b. Mail	ing Addre	ess (Street	and Number or Ru		er, City or Town, State	
Ž	alth a		Judith Wilson	(wife)	20 Er	ichan	nted I	Hills Rd	Apt. 1	Owings Mil Maryland 20c. Location - City	ls, 21117
စ်	He item		20a. Method of Disposition	20b	. Place of Disp cemetery, cre	osition (A	vame of or other pla	ce)	Dete	20c. Location - City	or Town, State
Ë	Page ent nt: H ry or		1 ☐ Burial 2 <b>∑</b> Cremation 3 ☐ 4 ☐ Donation _5 ☐ Other (Specify	Hemoval Irom State			emato		30/06	Catonsvil	le, Maryland
Baltimore,	permit. Pages 1 and 2 should by Department of Heath and Menta Importent: If item 27 is marked any injury or other treumatic events.		21. Signature of Funeral Service Licen	500						L Home, In	
ă	P P P P		o karen to	expet		ourge R631	е-лег Falla	iss-seitz Road F	Z runera. Raltimora	ı ноте, in e, Marylan	c. d. 21211
-á			23a Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the de	ath. Do not en	nter the m	node of dyin	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final	2)	, * A						Onset and Death
	/Medical		disease or condition resulting in death)	a. PNEUMON Due to (or as a cons							
8	Examiner			RENAL F	FAILUR	25					
- 4	# J	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	equence of):						
	s be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C							
<u></u>	exec an an rial-tr		resulting in death) Last	Due to (or as a cons	equence of):						
	ysicie bul	cal	(	d							
9	leath certificate attending physi I for use as the l	Physician/Medic					<del></del>				
Rox	h cer endir use	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pred 1 Live birth 2 F		□Ectonic	pregnanc	v		23d. Date of	
n	deat death death	icis	in the past 12 months?	4 Pregnant at time of		Other		,		Month	Day Year
J.	of the by the tache	hys	9 Unknown	9CI OTIKTOWIT							
Ś	The law requires that the death certuicate are has been signed by the attending phy: page 2 should be detached for use as the	by F	Part II. Dther significent conditions of	ontributing to death but not i	resulting in the	underlyin	g cause giv	ven in Part I.			to the cause of death?
Division of Vital Records,	w require been sign								1 🗆 '	Yes 2□No 3□	Probably 4 Unknown
ပ္တ	awre is be	Completed							24a. Was		autopsy findings available to completion of cause of
ž	The I	Eo							perfo	rmed? death	17
<u>ra</u>	en: tifica tor, p	Be C	25. Was case referred to medical					26. Place of De	ath (Check only o	7	30 24.00
>	ysici s cer direc	To B	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3	DOA Ott	ner: 4 🗆 Nursing F	Home 5 ☐ Resi	dence 6 Other (S	pecify)
ō	a Physical Seran Seral S		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time		28c. Inju			how injury occurred	
0	a fun	atio	1 Natural 5 Pending 2 Accident investigation		) Injury	М		Yes 2 □No			
S	Attendir death ector: A	ifica	3 Suicide 6 Could not be determined	289. Place of Injury - A		treet, faci	tory, office		28f. Location (		Rural Route Number,
	all or	Certification:	4 Tronnoide	building, etc. (Spe	city)				Ony or 7 or	mii, Statey	
	To the Hospital or Attending Physicien: The law within 24 burus after death.  To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of my l	nowledge, dea	th occurr	ed at the ti	me, date and place	e, and due to the	cause(s) and manner	as stated.
	n 24 ha Fu	Medical	(Check only 2 Medical Examone)	niner: On the basis of exam and manner stated.	mation and/or i	rivestigati	ion, in my	ppinion, death occ	urred at the time,	uate and place, and o	ane to the cause(s)
	To the within 2 To the Complet	Σ	29b. Signature and title of certifier	, ,			29c. Licen:			29d. Date signed (M	
)			Danier lake	brown h. N	מי		156	9427	394	MARCH &	27, 2006
	5-51		30. Name and address of person who	completed cause of death (	tem 23a) (Type	Print)				, , , , ,	
_ (	/ '		KENNEDY GAB	REGIORLISH	MD						
	Sta		31. Date filed (Month( Day, Year)	32. Registrar's Si	gnature	bark	1				
	Regist	rar	MINU 4 A	UUU JARARA	State of the	Charles Charles	_				

			For State Registrar	State of Maryland / Depa	artment of Health and N	lental Hygien	2000 10000	
	Physici /Medic		1. Decedent's Name (First, Middle, Last,	Wadsworth, S	SR.	2. Date of Death Month D. March 2	ay 2006 /25/3 m	
	Examin		4a. Facility Name (I not institution, give Franklin Squa	the Hospital	4b. City, Town or Location of Death	24	c. County of Death Balfimore	
	Funeral Director		5. Social Security Number  6. Septid Security Number  10  Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year 12-29-9	9. Birthplace (State or Foreign Country)  9. BACTINGREME	۷
	Maryland f show	lor	10a. State 10b. County	10c. City, Town or Lo	SACTIMORE		10d. Inside City Limits 1 ☐ Yes 2 ☐ H6	
	with the	i Direc	10e. Street and Number	Rd Ant A-	10f. Zip Code	10g. C	Citizen of What Country?	
36	irs after death	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∏Yes 2 ∏MA6	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or Iteme 23a or 28e-f ehow ent, the Madical Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Dece (Give College (1-4or 5+)	dent's Usual Occupation skind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry	-
land 2	id be filed ental Hygi ked other ic event, i	To Be Co	17. Father's Name (First, Middle, Last)	Wadsworth.		e (First, Middle, Maide		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Iteme 23a or 28e-f show way highly or other treumatic event, the Madical Examiner must be notified at ance.		19a. Informant Name/Relationship (Ty	99, Print) 19b. Maili  19b. Maili  20b. Place of Discount or company on	osition (Name of matory or other place)	pt A-1 B	or Town, State, Zip Code)  A CTIMORE MO 212  Location - City or Town, State	Ž,
Baltimore,	permit. Pages Department of I Importent: If Its any Injury or o		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ucens	Loudon Ba	CK Come try 4/1/ 2. Name and Addres Jot Facility 2 1005 Funcial Char	el 8800 H	MIS 21234. ARFORD RD.	
	Pnysician /Medical		23a. Part 1. Enter the disease, of compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	dations that cause the death. Do not en	ter the mode of dying, such as cardific EMbolism	or respiratory arrest,	Approximate Interval Between Onset and Death	
8760,	ate be executed hysicien and surial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
P.O. Box 6	wrequires thet the death certifics been signed by the ettending pt should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year	
rds, P	quires thet n signed b ald be deta	d by Pl	Part II. Other significant conditions con Lung Concert Po	ntributing to death but not resulting in the u	underlying cause given in Part I.  Abscess	23e. Did tobacco	use contribute to the cause of death?  2 No 3 Probably 4 Vinknown	
al Reco	i: The law rec icete has bee r, page 2 shou	Completed by	GI Bleed	•		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1   Yes 2   No	
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	tion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Magner of Death 1 SNatural 5 Pending 2 Accident Investigation	lospital: 1 A npatient 2 ER/Outpatien  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	nt 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5  Residence 28d. Describe how inj		-
Divisi	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
	he Hospita n 24 hours he Funere	Medical (	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Exami	sician: To the best of my knowledge, deat ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	and due to the cause( red at the time, date ar	s) and manner as stated nd place, and due to the cause(s)	
	To the Comp	₹	29b. Signature and title of certifier  M. > (	ZESIDENT PHYSICIA	29c. License number (2 (5 0 0 0)		ate signed (Month, Day, Year)  3/29/06	
	3		30. Name and address of person who comy THILL MUR	mpleted cause of death (Item 23a) (Type,	MD 9000 Frank	linsquare:	Drive Balta Md 2/23	3
	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 4 200	32 Registrar's Signature	we	V		

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death . 2006 March 29, Year **Physician** 7:35 Alice Kistler Lawson Willard ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 405 Brightwood Club Drive Baltimore Lutherville 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 97 441-34-3962 Yrs 0k1ahoma Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or iteme 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Baltimore Lutherville Director 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code 405 Brightwood Club Drive 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: White 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If tiem 27 ie marked other tha eny injury or other treumatic event, Ilna, once. Philanthropist Philanthropy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William L. Kistler Emily Hagameir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Edward Lawson, Jr./ Son 1920 E. 41st Street Tulsa, Oklahoma 74105 20a. Method of Disposition

1★ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4/7/06 Memorial Park Cemetery 4 □ Donation 5 □ Other (Specify) Tulsa, Ok. Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Puneral Service Licensee Approximate Interval Between On, et and Death 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aspiration days Physician /Medical Due to (ords a consequence of): Examiner Inlhiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part J. 23e. Did tobacco use coptribute to the cause of death? ð Disease 2 1 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 Z No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death Check only ne examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Aftert 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral C 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of ertified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 630 L 110~ Connell 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2006 Registrar

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. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2006 APRIL 1, Physician 12:40 P M WOLKSTEIN SYLVIA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PIKESVILLE BALTIMORE NORTH OAKS HEALTH CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 12/30/1918 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕡 F Yrs. MASS. Director 217-34-4196 87 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itams 23s or 28s-f show the Medical Exerciper must be notified at 1 ☐ Yes 2 ☑ No Director PIKESVILLE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21208 725 MT. WILSON LANE Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status within 72 hours after 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: ģ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) al Hygiene. Elementary/Secondary (0-12) NURSING REGISTERED NURSE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H 7 ie marked ot SHATZ TOLCHINSKY MARY ISIDOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 le
any injury or other trau 8513 MEADOWSWEET ROAD - BALTIMORE, MD 21208 BARBARA KAGEN / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State REISTERSTOWN, MD 04/03/2006 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM ! 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) engenhue Heart Physician 2 months /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an pace 2 s has autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Chack only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) w 3/06 038675 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE JOEL 301 ST PAUL CL #605 4202 MESHULAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2006 Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

Registrar

APR 0 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 31, 2006 **Physician** ADELAIDE E. ZAJAC 6:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Parkville Oak Crest If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 22, 1910 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 M 2 TyF Days Months Hours 95 216-03-3171 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f ahow other traumatic evant, the Mcdical Examinar must be notified at 1 ☐ Yes 2 X No Director Parkville MD Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 8820 Walther Blvd. Apt.2304 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ∐Yes If Yes, Give 1 Never Married 2 Married 2**X** No 1 ☐ Yes 2 ☐ No Specify: Specify: White 2 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H permit. Pages 1 and 2 should be Department of Health and Mental Important: If itam 27 is marked o Matilda Sabatini Dellorto Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21234 8820 Walther Blvd.Apt.2304-Parkville,MD Felix E. Zajac-Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō Dulaney Valley Mem. Gardens 4-6-06 Timonium, Maryland injury 22. Name and Address of Facility 21. Signature of Funeral Service Licensee EVANS FUNERAL CHAPEL 8800 Harford Road-Parkville, MD 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongeit Physician /Medical Due to (or as a consequence of): **Examiner** SCVD Supertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ tabrillative 1 Yes 2 1No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an certificate has autopsy performed? 1 Tes 2 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 mrsing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide a Funaral I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 the 2 D30182 mille D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2200 Witte Blud Bathrare MD 2134 messell MD 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State APR 0 4 2006 Registrar

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		25	ý	1. Decedent's Name (First, Middle, Last)				0, 004	2. Date of Death	1	3. Time of Death
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u		/Medi Examir		4a. Facility Name (If not institution, give s				vn, or Location of Death		4c. County of Deat	n
				UPTERCHESAPEAKE				BEZAIR		HARFO	1 N
		Funeral	(RE1970)	5. Social Security Number 6. Sex	M 2DE	(In yrs. last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day,	9. Birth 2, 1936 Ir	nplace (State or Foreign untry)
	15	Director		091-40-3219 Usual Residence of Decedent	x 69	115.			April I	2, 1930 Ir	an
		yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
		Mar a-fet	ctor	Md. Harford		F	Bel Air				1 ☐ Yes 2 🖾 No
		death with the Maryland me 23s or 28s-f show richal be notified at	Director	10e. Street and Number			10f. Zip Co	de	10	g. Citizen of What Co	untry?
		ath w	rai	2310 Cullum Road			2101.			U.S.A.	
		er de	Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ev Armed Forces?		Was Decedent If Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
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	21215-0036	2 hou		15. Decedent's Educ	cation	16a. Dece	dent's Usual O	ccupation	4-10-	16b. Kind of Business/	Industry
20	218	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use n	one during most of wor etired) surgical	King	1.	
8	21	ed wi	Con		5+	physi	cian	oncologist)		medical	
	ng	be fill htal H d oth	Be	17. Father's Name (First, Middle, Last) Zena Albedien				18. Mother's Nar Shokat	ne <i>(First, Middle, N</i> Namazi	faiden Sumame)	
	7	hould d Mer marks marks	5	19a. Informant's Name/Relationship (Ty)	na Printi	10b Maili	na Addraga (Ci	reet and Number or Ru		City or Town State 7	(in Code)
9	Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene Important: if Item 27 is marked other than "natural; or itame 23s or 28s-f show any injury or other traumatic avent, the Medical Example Trans to notified at Once.		Dottie Arfaa/wife	56, 1 (11)()			Road, Bel			.p 0000)
0	ē,	Hea Hea Hem		20a. Method of Disposition		20b. Place of Dispo	osition (Name o	of !		20c. Location - City or	Town, State
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				23a. Part1. Enter the disease, or compli shock, or heart failure. List only on	cations that caused the cause on each line	ne death. Do not en	ter the mode of	dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition		HASC	J 1)				Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	-				
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$\approx$	89	certifical	Physician/Medi	IF FEMALE:							
2	Box	ath ce ittend or use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pregn			23d. Date of deli Month	very Day Year
1		the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tii 9 Unknown	me of death 5 (	Other (specif	ý)			
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0	Re	The la	E						autopsy perform 1 Tes 2	ned? death?	completion of cause of 2. No
S	ital	rtifica	BeC	25. Was case referred to medical	- All 5 17			26. Place of Dea	th Check only one		2,25110
D	<b>5</b>	Physician: this certific ral director,	10	examiner? 1 AYes 2 No	ospital: 1 🗌 Inpatient	2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing H	lome 5 Reside	nce 6 Other (Spec	cify)
2	0	ing Pl		27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day 1	Year) 28b. Time o		Injury at Work?	28d. Describe ho	w injury occurred	
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rfaa, Manocchehn	Division of Vital Records,	or At after d Direction by	Certification;	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, st (Specify)	reet, factory, of	fice	City or Town	reet and Number or Ru , State)	rai Houte Number,
1	J	spitel nours nerei		29a. Certifier 1 Certifying Phys	icien: To the best of	my knowledge, deal	h occurred at ti	he time, date and place	, and due to the ca	use(s) and manner as	stated.
I		To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical		er: On the basis of e and manner state	xamination and/or in	vestigation, in	my opinion, death occu	irred at the time, da	ite and place, and due	to the cause(s)
		To th within To th comp	Me	29b. Signature and title of certifier				cense number		d. Date signed (Month	**
				I anosal mi	+ r	1.5.	۵	21800	^	PNILIST	2006
		DD		30. Name and address of person who co							
	100	X.			10 23 Pagistra		CIL NO	T. MO	ろうごろ	MO2159	3
		Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar	s signature					

CPM 06-02218 Gloria Aquinago

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  Gloria Violet Aguinaga  4a. Facility Name (If not institution, give street and number)  2803 Overland Avenue  Superal  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24 Hrs.   8. Date of Birth	31, 2006 07:57 AM
An Examiner  4a. Facility Name (If not institution, give street and number)  2803 Overland Avenue  4b. City, Town, or Locetion of Death  Baltimore	4c. County of Death
2803 Overland Avenue Baltimore	
	N/A
Director 214-64-3913 1 M 2 N F 52 Yrs. Months Days Hours Min. (Month, Day. Jan. 19	year) 9. Birthplace (State or Foreign Country) 1954 MaryLand
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
Maryland N/A Baltimore	1 <b>)</b> Yes 2 □ No
Maryland N/A Baltimore    Maryland N/A Baltimore   106. Zip Code   107. Zip Code   108. Zip Code   109. Zip Co	g. Citizen of What Country?
2803 Overland Avenue 21214  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.  14. Race - American Indian,
Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give 1 Yes, Give 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify:	Black, White, etc.  Specify: White
15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	6b. Kind of Business/Industry
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  11th Grade  11th Grade	Drug Store
The first of the f	aiden Sumame)
Rafael Marzola, Jr.  Rafael Marzola, Jr.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Bural Boute Number,	
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Mrs. Violet A. Arnold (mozner) 345 Uld Wesaminszer Road, fland  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	0c. Location - City or Town, State
1 □ Burial 2 文(Cremation 3 □ Removal from State Bayview Crematory 4/4/06	altimore, Maryland
20a. Method of Disposition    Date   2   20a. Method of Disposition   3   Removal from State   4   Donation   5   Other (Specify)    21. Signature of Pineral Service Licensee   22. Name and Address of Facility Schimunek Full   9705 Belair Rd., Baltimore	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line.	st, Approximate Interval Between Onset and Death
Physician   Immediate Cause (Final disease or condition resulting in death)	Crissi and Doubl
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	
Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
SPLO39 A graph of the part of	23d. Date of delivery  Month Day Year
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	ed? dealh? □ No 1 2 Yes 2 □ No
25. Was case referred to medical examiner?  1	ice 6 X Other (Specify) SCENE
27. Manner of Death  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  Work?  28d. Describe how Work?	vinjury occurred Singre It in male
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o € o € ≥ 29b. Signature and title of certifier 29c. License number 29	d. Date signed (Month. Day, Year)
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			1 - For State Registrar	State of Maryla		artment of		d Mental H	ygiene Reg. No.	006	10398
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	Physici /Medi		THOMAS	J.	A	BERCROP	MBIE	APRIL	Day 3	2006	1234 PM
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			THE TOHNS HOPKIN	45 HOSPITAL		BALTI	MORE				
	Funeral		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday)	If Under 1 Ye Months Day			Birth Day, Year)	9. Birth	place (State or Foreign
	Director		919.28.6888	7	5 Yrs.			8-13			INESOTA
	and		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation					10d. Inside City Limits
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	289	Director	10e. Street and Number	UOL	DINITU	10f. Zip Code	·		10g. Citiz	en of What Cou	intry?
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9	or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☑ 1es 2 ☐ No	1			uerto Rican, etc.)		Black, White	, etc.
5-003	ours	b b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: [95]	-52	1 □ Yes 2 🗹 N	No Specify:		5	Specify: Wh	NITE
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Maryland 2121	ntal h	Be	17. Fairlet's Name (Pirst, Middle, Last)	>4 . A . C			D	Name (First, Midd	le, Maiden S	Surname)	
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<u>8</u>	s 1 and 2 should be filed within 72 hours after death with the Marylan if Hauth and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f ehow other traumatic event, if a Medical Exist in ar mast he notified at		11 . · · · · · · · · · · · · · · · · · ·				25.315	r Rural Route Num			p Code)
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altimore,	artme ortan injur		4 □Donation 5 □Other (Specify, 21. Signature of Fun II Service Livens	HIV	MONYC	. Name and Add		-4-06	HAN	OUER,	Mg
Ba	permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trau		MIXX	Tank		Daughert	y Family Funer	al Home And Cr			
			23a. Part1. Enter the disease, or comp	lications that caused the dea	ath. Do not ent			oad - Pasadena diac or respiratory		22	Approximate
	Dhysisian		shock, or heart failure. List only of Immediate Cause (Final	ne cause — each line.				,			Interval Between Onset and Death
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5	ding h. After funer	틸	1 SNatural 5 ☐ Pending	(Month, Day Year)	Injury	28c. In W	luryat /ork? □Yes 2□No	28d. Describe	now injury	occurrea	
DIVISION	death death ctor: y the	lica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home farm str			28f Location	/Street and	Number or Rum	al Route Number,
$\leq$	after after Dire	Certification:	4 Homicide determined	building, etc. (Spec	ity)	ot, radiory, offic	•	City or T	own, State)	TTUINDEN OF THUIS	arriodie reditoer,
	spits nours nerai		29a. Certifier 12 Certifying Phy	sician: To the best of my kr	owledge, death	occurred at the	time, date and pl	ace, and due to the	e cause(s) a	nd manner as s	tated
	P Fu	Medicai	(Check only 2 Medical Examione)	ner: On the basis of examinand manner stated.	ation and/or inv	estigation, in my	y opinion, death o	ccurred at the time	, date and p	lace, and due to	o the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	×	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date	signed (Month,	Day, Year)
1			HILA	mo		R	ES - ODC		APRIL	3 28	006
	20		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)					
			DEBA SARMA	600 NORTH	WOLF	E STRE	ET BA	LTIMORE	MAR	YLAND	21287
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature						
3	Registra	II.	APR 0 5 2006	Bo . 1	40	- 49					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1399 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 2006 March 21, 4:15 PM M Bernadette Elizabeth Arnett /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pasadena Anne Arundel 671 210th Street 8. Date of Birth (Month, Day, Youly 30, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Year) 1922 Maryland **Funeral** Months 1 □ M 21 F Yrs 216-12-7943 83 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h Count or 288-f show r than "natural", or Items 23a or 28e-f ehov the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21227 USA 1940 Victory Drive Funeral unk

12. Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 M No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 clerical other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Int. If item 27 is marked o Orval Charles Arnett Hilda Gertrude Crothers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if item 27 Is: any injury or other traus 671 210th Street Pasadena, MD Marianne Arrington/niece 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 Donation 5 ☐ Other (Specify) 21. Signature de Funeral Sen les Licensee Ronald S Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street mu 21201 Baltimore, MĎ or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part Enter the disease Approximate Interval Between or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical to (or as a consequence of) **Examiner** Souventially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months: jo Month Day Year 5 Other (specify) should be detached the 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 2-No Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA this 27. Mann Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. s after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funerel C
completely filled i filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2630 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 202 0 31. Date filed (Month, Day, Year) State Registrar APR 0 5 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month SOLANGE AVERSA APRIL 1, 2006 8:58 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 631 MEADOW BRANCH RD. WESTMINSTER CARROLL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 27 F 217-32-9396 79 Yrs. Director FRANCE 10/9/1926 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f ehow r than "naturel", or itema 23a or 28a-f ehov the Medical Examinar must be notified at MD CARROLL WESTMINSTER 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 631 MEADOW BRANCH RD. 21158 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE δ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 le marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 CASHIER GROCERY STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental GILBERT ROUX MARTHA LECLERCO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 le m eny injury or other traum once. JOSEPH M. AVERSA -HUSBAND 631 MEADOW BRANCH RD., WESTMINSTER, MD 21158 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Berial 2 □ Cremation 3 □ Removal from State LAKE VIEW MEM. PARK 4/5/06 SYKESVILLE, MD 21. Signatur of Figeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUPRANUCLEAR PROGRESSIVE years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine certificate be executed burial-transit Due to (or as a consequence of): attending physicien Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ■ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached Ö 9☐ Unknown 9 Unknown δ signed l d be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> CORONARY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed? 1 ☐ Yes 2 No certificete 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 No ٩ 1 Tes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this funeral of Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARTHUR L. RUDO MS 904 WASHINGTON RD WESTMISTER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Leona Burrows 2:03 P. M March 28 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3809 - 8th Street Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 4, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 214 18 3818 Director 85 Mary Tand Usual Residence of Decedent with the Maryland or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A 1K Yes 2 No Maryland Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Madical Examinar must be 3809 - 8th Street U.S. 21225 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) Cotlege (1-4or 5+) Secretary 12th Hardware Company Pages 1 and 2 should be filed vitnent of Health and Mental Hygie rtant: If Item 27 is marked other to jury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Keil Augusta (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau Carlton Burrows / son 1202 Lindwood Drive Carter Lake, Iowa 51510 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/31/2006 Glen Burnie, Maryland Glen Haven Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) To for ctrom **Physician** Myocordial /Medical Due to (or as a donsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physicien Physician/Medical ₽ E attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown this certificete hes been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home Statesidence 6 Other (Specify) 1 Yes 2000 2 FR/Outpatient 3 DOA Aftar this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after de. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide ö To the Hospital o within 24 hours aft To the Funeral Di completely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 007930 no completed cause of death (Item 23a) (Type, Print) PAUL PLACE, BALTO, MD 21202 31. Date filed (Month State Registrar

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Herman E. Bullock Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item per int 855 5-9-06 vt
State of Maryland / Department of Health and Mental Hygiene 06-02266 CT10403 1- State of Death Registrar 19b per FH G854 4/5/06 Grate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** BULLOCK April 01 2006 4:44 P <sup>№</sup> HERMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown
If Under 1 Year If Under 24 Hrs. 8711 Gilly Way Baltimore 8. Date of Birth (Month, Day, Birthplace (State or Foreign, Country) 5. Social Security Number 01 7. Age (In yrs. last birthday) 6. Sex Days **Funeral** Months Hours 12 M 2□ F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health end Mantal Hyglene.
and: If item 23 is marked other then 'naturel', or Iteme 23a or 28a-f ehow and it if item of 10 in marked other then 'naturel', or lother treumatic event, ite Mudical Examina in must be notified at 1 ☐ Yes 2 No Directo BALTIHORE DWING MARYLAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number F5 MILL 0 Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-1: mentary/Secondary (0-12) College (1-4or 5+) WORKER ONSTRUCTION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 11 LOCK ERMA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3600 FRANKLY ECELIA KOBBINS(MOTHER) APT, IZK BALTO, ST MD, 21229 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State CEMETERY permit. Page Department of Important: If eny Injury or 04-07-06 LANSDOWNE 4 □ Donation 5 □ Other (Specify) BROWN R. FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BALTO. MD. 212 TON AVE 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Purplie **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Year in the past 12 months? Dav 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

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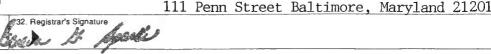
State Registrar

THE WORE MIKE 31. Date filed (Month, Day, Year) APR 0 5 2006

history

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



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OCME

April 02, 2006

			1 - For State Registrar	State of	Maryla				lealth and Death	d Mental Hy	/gień	• 4 6 6	Tarana a	**************************************
	Dhysia	ion	1. Decedent's Name (First, Middle,	Last)						2. Date of D Month			3. Tir	ne of Death
	Physic /Medi		Dorothy Berto	let						April	03	Year 2000	0 111	5 A M
}	Exami		4a. Facility Name (If not institution,	give street and numb	ver)		4b. City	, Town, or	r Location of De		4	c. County of Dea	th	
		**	St Agnes H	lospital			13	11/2	morle	_				
2	Funeral		· ·	. Sex 7. 1 ☐ M 2 ☐ XF	Age (In yrs	. last birthday)	If Unde	or 1 Year Days	If Under 24 H	Irs. 8. Date of B. (Month, D	irth	9. Bir	hplace (St	ate or Foreign
4	Director		578-14-4170	TLIM ZLANF	91	Yrs.	Nonara	Days	Tiodis	Nov.19	,191	4 Wise	ountry) Consi	n
	put *		Usual Residence of Decedent  10a. State 10b. County		10c C	ity, Town or Lo								
	the Marylar 28e-f show	<u>_</u>			100.0	aty, Town or Lo	ocation							de City Limits
	8a-f	octo	Maryland   Baltimo	ore		Cato							1 🗀	Yes 2⊠No
	vith t	Director	10e. Street and Number				10f. Zi	p Code			10g. C	itizen of What Co	untry?	
	ath v	rai	4 MacIntosh Cour					2122			US	A		
	er de	Funerai	11. Marital Status	12. Was Decede Armed Force	es?	J.S. 13.	Was Dece If Yes, spe	edent of Hi	ispanic Origin? in, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ame Black, Whit		n,
36	, or	by F	1 Never Married 2 Married 3 Wildowed 4 Divorced	If Yes, Give		1	1 🗆 Yes		Specify:			Specify:	Whi	te
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23e or 28e-f show its Madical Examiner must be notifited at	be		Year or Date	98:	1 10: 5								
15	n 72	Completed	15. Decedent's (Specify only highest of			16a. Dece	kind of w	ual Occupa ork done d use retired	during most of v	vorking	16b. k	Cind of Business	Industry	
12	within then	Ę	Elementary/Secondary (0-12)	College (1-4	or 5+)		emake		7			**		
0	fited withi Hygiene. other then		17. Father's Name (First, Middle, La	st)	-	поше	emake	r	18 Mother's N	lame (First, Middle		n Home		
an	d be antal red o	Be	George Stehfl						Augu			i Surname)		
2	should band Ments and Ments a marked umatic e	2	19a. Informant's Name/Relationship	(Type Print)		105 14-10		- (C)						
Maryland										Rural Route Numb				
	1 and 2 Health tam 27 i		Michael Bertol 20a. Method of Disposition	et Son	20h					ls Ave;	Sato	n Rouge,	LA	70810
פֿר	(D) (C)		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta	ite	cemetery, crer	natory or	other place	θ)			ocation - City or		
Baltimore,	permit. Page Department Importent: If eny injury o		4 □ Donation 5 ☒ Other (Spec		ent Lo							timore,		
Bal	Depa Impo eny i		21. Signatur 1 Fund al Service Lic	enso	///	22 H	. Name a Tuner	nd Addres a1 Ho	s of Facility S	terling A Catonsvil enue; Cat	\sht	on Schwa	b Wit	zke
	40200		Conha	10	er	16	30 Ē	dmon	lson Av	enue; Čai	ons	villė, M	D 212	228
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)		9 (	Panc	er the mod	de of dying	g, such as card	iac or respiratory a	rrest,		_ Onset a	mate Between and Death
	Examiner			Due to (or	as a consec	quence of):								
		ē	Sequentially list conditions,	b. Due to (or	as a consec	uence off.								
//	cate be executed physician and the burial-transit	Examine	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
ć.	exec n and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consec	quence of):								
8760,	e be rsicia e bur			d										
.89	death certificate be executed e attending physician and id for use as the burial-transit	Completed by Physician/Medical		d.										
Вох	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	ne of pregna	ancy						204 Data of dall		
m	death atte	cial	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pi					23d. Date of deli Month	иегу Day	Year
P.O.	that the de led by the a detached f	ysi	1 ☐ Yes 2 ♠No 9 ☐ Unknown	9□ Unknowr			(o),							
J.	The law requires that the ate has been signed by thogge 2 should be detache	Y P	Part II. Other significant conditions	contributing to death	but not res	ulting in the ur	derlying o	ause give	n in Part I.	23e. Did t	obacco i	use contribute to	the cause	of death?
Sp.	uires sign	q p	Congestive	111 6	ailu						Yes 2			□Unknown
õ	tw requires that s been signed I should be det	ete	Dana F 14											
Re	helay has	m	lenal failu	ICC						24a. Was	osy	24b. Were aut		ngs available of cause of
<u>_</u>	n: The			-						1 Tes	rmed? 2 🔀 No	death?	2 No	
Division of Vital Records,	Physicien: this certificatal director, a	Be	25. Was case referred to medical examiner?	Hagnital						eath Check only o	пе			
ō	this at dil	은	1 ☐ Yes 2 💢 No	Hospital: 1X Inpa		ER/Outpatient			4 🗆 IVUISIIIG	Home 5 Resid	dence	6 □Other (Spec	fy)	
Ĕ	After	o	27. Manner of Death 1 Anatural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury		28c. Injury Work	at ?	28d. Describe I	now injur	y occurred		
S	death death stor; / the fi	cat	2 Accident investigate 3 Suicide 6 Could not	ho -			М		es 2 No					
<u>≥</u>	after of Att Direct of In Direc	Certification;	4 Homicide determine	286. Place of	njury - At he etc. (Specif	ome, farm, stre y)	et, factory	y, office		28f. Location (S City or Tox	Street an	d Number or Rui	al Route N	lumber,
ِ ب	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	S										,		
	Hosp 4 hor Fune ely fi	edicai	29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medical Exa	hysician: To the be- miner: On the basis	st of my kno of examina	wledge, death	occurred	at the time	e, date and placinion, death occ	ce, and due to the	cause(s)	and manner as	stated.	2(2)
:	vithin 2 To the Complet	Med		and manner	stated.									
	1 × 5 0	-	29b. Signature and title of certifier	1			290	. License	number		≥9d. Dat	e signed (Month	Day, Yea	7)
			TWY					125	1811		A-P	13,2	006	
	Y		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type, F	Print)							
	,		Thomas Ghio	71 112	O No	orthi	Nolla	-, N	-d Ba	Hem,	me	21228	•	
	Sta Registra		31. Date filed (Month, Day, Year)  APR 0 5	2006 32. Pegis	irars Signa	ture	will			Him ,				

Dorth Bortely

State of Maryland / Department of Health and Mental Hygiene 📋 🗍 🔓 10406 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Bauder, Jr. March 2006 9:00 A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1 Thurmont Ct., Apt. 1D Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Vrs. Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral**  Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ F Director 073-05-6774 Yrs. 9-6-18 87 Canada Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Perry Hall 1 Yes 2 No Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with or Itams 23a 1 Thurmont Ct. Apt. 1-D 21236 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 β 1 ☐ Yes 2√☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or othar traumatic event, IFE Ma Elementary/Secondary (0-12) College (1-4or 5+) 3 yrs. Minister Religious Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William D. Bauder, Sr. Edna (Surname Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Bauder 1 Thurmont Ct., Apt. 1-D, Perry Hall, MD 21236 (wife) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Dulaney Valley Mem'l 4/3/2006 \* 4 ☐ Donation 5 ☐ Other (Specify) Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Juneral Service I 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CONSESTIVE Immediate Cause (Final Physician HEART disease or condition resulting in death) months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ó in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 Other (specify) of Vital Records, P.O. detached 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Isdiminal Completed 1 ☐ Yes 2 🗷 No 3 Probably 4 □Unknown Dementra 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.24No Depression 1 ☐ Yes or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28b. Time of after death. 28c. Injury at Work? 28d. Describe how injury occurred 1 SNatural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) dreno un 040480 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fenno, ms FERNANDO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1- State of Maryland / Department of Health and Mental Hygiene 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  April Day Year 12, Ol 6 M
B	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  PRINCE GEORGES  4c. County of Death  PRINCE GEORGES
10/	Funeral Director	8	5. Social Security Number 6. Sex 190 M 2 F 7. Age (In yrs. last birthday) 190 M 2 F 7. Age (In yrs. last birthday) 190 M 2 F 1
320	the Maryland 28a-f show notified at	٥	Toa. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD GLENARDEN 1 □ Yes 2 ⊠ No
×	death with the Maryland ms 23e or 28e-f show r must be notified at	Direct	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA
10e	P 2 2	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Molowed 4 Divorced 1 Never Married 2 Molowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Molowed 4 Divorced 1 Ne
B19E	21215-0036 od within 72 hours af gjene. or than "natural; or the Medical Exem.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry
7		To Be Co	12 TH GRADE 4 VRS CHIEF ENGINEER SHERATON SUTTES  17. Father's Name (First, Middle, Last)  NANCY COBB
	, Maryland and 2 should be file salth and Menial Hi n 27 is marked oth er trsumatic sysn		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19504 1 <sup>TH</sup> ST., GLENARDEN, MD 20706
	Baltimore, Ma permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other traten		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Location - City or Town, State
	Balt permit. Departi Import sny inj		21. Signature of Funeral Service Licensee VAUGHN C. GREENE FUNERAL SER. 5151 BALTO. NATL PIKE, BALTO. MO 21229
	Prysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)
	/Medical Examiner	-e	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):
V	58760, icate be executed physician and sthe burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.
	vision of Vital Records, P.O. Box 68760 Attending Physician: The law requires that the death certificate be er reform. After this certificate has been signed by the attending physician by the funeral director, page 2 should be detached for use as the burity.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1
	Cords, P	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 10 No 3 Probably 4 Unknown
	Division of Vital Records, to Attending Physician: The law requires that dear death. After this certificate has been signed in by the funeral director, page 2 should be compared.	Completed	CA-D SIP Start  PVD  24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ₹ No
	on of Vital Reding Physician: The Parter this certificate he funeral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only one)  Hospital:  1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)
	ision of		27. Manner of Death  1  Natural 5 Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  1  Note of Injury 28b. Time of Injury 38b. Time of Injury 48b. Time of Injury 38b. Time of Injury 48b. Time of Injury 38b. Time of Injury 4bb. Time of Injury 4bb. Time of Injury
	Divisio To the Hospital or Attendi within 24 hours atter death. To the Euneral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	he Hosp in 24 hou he Funel pletely fil	Medicai	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one) Section 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To I To I	2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  4)3)06
-	B		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  \$100 Good Cuch Read Suit 302 Conham, MD 20706
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 5 2006 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 15:18PM 2006 LEOLA 1. BROWN APRIL 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) HOSPITAL NA AGNES BALTIHORE If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days Months Hours 1 ☐ M 2 🗷 F Yrs. 216 · 36 · 5236
Usual Residence of Decedent 04.07.1920 MD 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 No NA BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 104 WALNUT AVENUE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 NWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) HOUSE KEEPER HOSPITAL 1014 GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LUTHER JOHNSON ELLA M. WILLIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DONXELLA M. TYSON (DAUGHTER) 104 WALNUT AVENUE, BALTO, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State PARK 04.11.06 4 ☐ Donation 5 ☐ Other (Specify) KING RANDAUSTOWN 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 21. Signature of Euneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTEROSCLEROTIC CORONARY ARTERY DISEASE UNKNOWN Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 D No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERCHOLESTEROLEMIA 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death

1 Natural
2 Accident 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No

Examiner attending physicien and for use as the burial-transit of Vital Records. Division death.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

other then "naturel", or iteme 23e or 28a-f ehow vent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked oth any lighty or other treumatic event SIME.

**Physician** /Medical Direct

Funeral

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Completed

Be

Examiner

Iclan/Medical

Physi

Be Completed by

Certification: To

3 Suicide

29a Certifier

4 | Homicide

31. Date filed (Month, Day, Year)

with the Maryland

neral Director: After this certificate hes been signed by the filled in by the funeral director, page 2 should be detached Hospital or Attending after death within 24 hours at To the Funeral D completely filled it

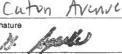
Medical State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PAICK. MD 900 ) onl

6 ☐ Could not be

32. Registrar's Signature APR 0 5 2006



29c. License number D47353

Balthwere,

Location (Street and Number or Rural Route Number, City or Town, State)

Mary

29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

Registrar

APR 6 5 2006

11:00 р.ш.

		1 - For Stata Registrar	State of Maryla	and / Dep		lealth and		iene	Parameter Communication of the
·	- 250	Registrar  1. Decedent's Name (First, Midd	lle, Last)		Tillicate of t	Jean	2. Date of Dear		3. Time of Death
Phys /Me	ician dical	Edward B. Br	own				March	<sup>Day</sup> 200	2026 M
	niner	4a. Facility Name (If not institution	on, give street and number) Medical Cente	r	4b. City, Town, or Annap		eath	Anne A	Death Tundel
Funera	al l	5. Social Security Number	6. Sex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 H			Birthplece (State or Foreign Country)
Directo		217-40-6242	1 <b>X</b> M 2□ F	64 Yrs.	Months Days	Hours M	Dec 11	1941 M	laryland
land ow		Usual Residence of Decedent  10a. State 10b. County	/ 10c.	City, Town or Lo	ocation				10d. Inside City Limits
e Many a-feh liftied	cto	Maryland Anne	Arundel	Annapo	olis				1 <b>X</b> (es 2 □ No
death with the Maryland me 23a or 28a-f ehow rmust be notified at	Directo	10e. Street and Number 211 Admiral	D۳		10f. Zip Code 2140	1	1	0g. Citizen of Wha	it Country?
Jeath The 23	Funerai	11. Marital Status	12. Was Decedent Ever in	I U.S. 13.			(Specify Yes or No- uerto Rican, etc.)	14. Race -	American Indian,
13-00.30 72 hours after death with the Marylar "natural", or Iteme 23a or 28a-1 ehow after Ensire or mark to notified at	ò	3 ☐ Widowed 4 ☐ Divorce	If Yes Give		If Yes, specify Cuba 1 ☐ Yes 2XXIVo	n, Mexican, Pu Specify:	uerto Rican, etc.)		White, etc. Black
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Z I Z I 3- J within 72 Jiene. T then "nate	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1	olic Wor			City of	Annapolis
fiand Z I Z I uld be filed within Mental Hygiene. arked other then stilc event, the Men	a)	17. Father's Name (First, Middle)				_	Name (First, Middle, I	Maiden Sumame)	
hould I	၉	Edward Brown  19a. Informant's Name/Relation		19h Maili	ng Address (Street		Rural Route Number	City or Tourn Sta	to Zin Codel
Mai nd 2 st alth and 27 le n rr traun		Joan Brown (W					nnapolis		
ore, of Height Inches		20a. Method of Disposition 1 △ Burial 2 □ Cremation	3 DRemoval from State	Place of Dispo	osition (Name of greatery or other place	θ)	Date	20c. Location - Cit	y or Town, State
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Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked eny Injury or other traumatic ex	Suc	Larry A	Rees MOOY8	3 8	m. Rees 21 West	e E So St. A	ns Mortu Innapolis	ary, P.	A. 1401
(See	190	23a. Part1. Enter the disease, or shock, or hear failure. Lis	or implications that caused the det only one cause on each line.						Approximate Interval Between
Physicia		Immediate Cause (Final disease or condition resulting in death)	a	Enul	1001/V	16-			Onset and Death
/Medica Examine			Due to (or as a cons	equence of):	Gans	MAR			
/ p ≓	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cons	equence of):	J	, , , , ,			
be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a cons	equence of):					
F.C. BOX 68/60, that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	calE		d						
ortifical ing phy e as th	-	I .	T						
Geath certifica death certifica e attending ph d for use as th	Physiclan/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of prec 1 Live birth 2 Fe 4 Pregnant at time o	etal death 3[	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
the d	hysi	1 Yes 2 No 9 Unknown	9□ Unknown						
sign d be	à	Part II. Other significant condit	ions contributing to death but not r	resulting in the u	inderlying cause give	en in Part I.			te to the cause of death?  Probably 4 Unknown
aw aw	ompieted	-					24a. Was a autops	y / prior	e autopsy findings available to completion of cause of
Th Th	O							200/10 10	Yes 2□ No
OT VITAL Physician: 1 this certifical ral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital	☐ ER/Outpatie	nt 3□ DOA Othe	200	Death <i>(Check only on</i> g Home 5 ☐ Reside		Specify)
T g je je				28b. Time o Injury	Work	at		w injury occurred	
VISION Attending ar death. ector: After by the fune	ficat	2 Accident invest	mined   286. Place of Injury - At	t home, farm, st		Yes 2 □ No	28f. Location (St	reet and Number o	or Rural Route Number,
rs after al Dire	Certification:	4 Homicide	building, etc. (Spe	ecify)			City or Town	n, State)	
DIVISIO  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Certifyi (Check only 2 Madical	ing Physician: To the best of my k I Examiner: On the basis of examinand manner stated.	knowledge, deat ination and/or in	h occurred at the tim exestigation, in my op	ne, date and pla pinion, death of	ace, and due to the caccurred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)
To the To the Comp	Σ	29b. Signature and Ittle of certific	1/1/10	V	29c. License	number	2	9d. Date signed (A	forth, Day, Year
h		30. Name and address of person	who completed cause of death (II	tem 23a) (Type	Print)	1710		03/30	1200
9		In W	(-100) MA	GUC	Ridir	1 /1/V	2 An	nipul):	mo
Regi	State strar	31. Date filed (Month, Day, Year APR 0 5	2006 32. Registrar's Sig	nature	W	/	/	V	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- state Registramend Item #2 PER Phy G854 4/95/tifecate of Death Reg. No. 2. Date of Death April 03, 2005 Time of Death Month Day Year 1. Decedent's Name (First, Middle, Last) **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Baltimore SAMATHAM Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 M 2□F 214 505995 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Altimore 1 Yes 2 □ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? USA Tarkuny Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ō RICAN AMERICAN 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PARALEGAL uned to Health and Mental Hyg. 17. Father's Name (First, Middle, Last) CAKley M. Bailes Theresa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) - BAltimore MARYland 21229 VElmA Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition emetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON Forest VA Owings Mills, MANN And 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
NAMEY M. CONTINE FUNCTION SERVICE 3405 W. FRANKLIN Street-BALTIMORE MARYLAND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Inlerval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list cunditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner sicion and burial-transit Due to (or as a consequence of) P.O. Box 68760. the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 XNo 1 x Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending

or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. To the Funerel Director: A the To the Hospital

Medical Certification: To completely filled in by

Registrar

SouzolaLnitsKI 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

4 Homicide

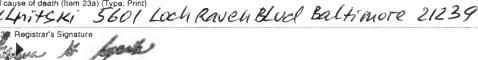
investigation

4 2006

6 Could not be determined

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

Res 000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

ADH FRANCIS BORIAH 06-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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1	Examir		4a. Facility Name (If not institution,	give street and nur					Location	of Death	Tirucon		County of		10230	Π
			BAYVIEW HOSPITA	Ĺ			BALT:						Ba1t	timo	re	
Į.	Funeral Director		Unkown	5. Sex 1 □ M 2 Ø F	7. Age (In yrs. I 53	ast birthday) Yrs.	If Under Months	1 Year Days	if Under Hours	24 Hrs. Min.	8. Date of Bi	7,19	52	Mar	lace (State try) yland	or Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c, City	, Town or Lo	cation							1.	0d. Inside C	Titu Limite
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itame 23s or 28s-1 show say injury or other traumatic avant, the Medical Examinar must be routiled at ance.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Dovorced	Armed For	2 <b>[2</b> No e	'	Was Deced f Yes, spec		spanic Or n, Mexica Specify		ecify Yes or No Rican, etc.)	D-	14. Race - Black, Specify:	White, e		
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JOAN BROWN

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	Physic	ian	Decedent's Name (First, Middle, Last)							<ol><li>Date of De Month</li></ol>	Da		er	3. Time of E	
	/Medi	cal		becca H. Bak	er	1 4 0	<b>T</b>			March	30,	2006		8:34	P <sup>M</sup>
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_			5. Social Security Number 6. Sec		. last birthday,	If Linde	r 1 Year	If Under 24		8. Date of Bir		ontgom		00 (Chata	Conto
	Funeral Director			M 2∏F 91	Yrs.	Months			Min.	July 1	ay, Year	914 Wa	COUNTRY	ce (State or !) 19 ton.	
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	item item	- T	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in t Armed Forces?	J.S. 13.	If Yes, spe	dent of Hi city Cuba	spanic Origir n, Mexican, F	n? (Spec Puerto R	ity Yes or No ican, etc.)	o-	14. Race - A Black, V	American Vhite, etc		
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<u>yla</u>	should be ind Mental marked o umatic eva	P	Elijah Heffner					Bert	tha	Vinson	ì				
Maryland	~ ~ ~ =		19a. Informant's Name/Relationship (Ty	oe, Print)								or Town, Stat			
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É	ii or Attar after dea Diractor d in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, str fy)	eet, factor	/, office		28	f. Location (: City or To	Street ar wn, State	d Number or	Rural R	oute Numbe	3/,
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edicai C	29a. Certifier 1 X Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	h occurred vestigation	at the tim , in my op	e, date and p inion, death o	olace, an	d due to the at the time,	cause(s)	and manner place, and c	as state	e cause(s)	
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	·		· U. W.	Uman,	MD		D0046	5734			Apr	i1 3, :	2006		
	$\chi$		30. Name and address of person who con	771-1	m 23a) (Type,	Print)									
	' \		Irene Feldman, M.I			Road,	#1-4	, Betl	hesd	a, Mar	y1aı	nd 208	14		
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		1	For Stete Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of F			ene 05	15
ı	The state of the s		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		ERNEST WALLACE B	IAS				MARCH 31	, 2006	8:00p M
. <sub>18</sub>	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, o	or Location of Death		4c. County of Dear	h
			624 HILLVIEW RD.			BALTI			N/A	
影	Funeral		5. Social Security Number 6. Sex X	M 2FF	(In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bin	hplace (State or Foreign
ь	Director		217-03-8353		87 Yrs.		<u> </u>	2-6-191	9 MAR	YLAND
	and w	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	f sho	5	MD. N/A		BALTIMO	าอะ				1 XYes 2 □ No
	the 28a-	Director	10e. Street and Number		DALITA	10f. Zip Code		10	g. Citizen of What Co	ountry?
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SUC.		Be	CALVIN BIAS					WALLACE		
چ	should be filed within 72 hours after death with fhe Marylan of Manderla Hygiens and Hygiens marked other then "naturel", or flems 23s or 28s-1 show marked other then "naturel", or flems 23s or 28s-1 show marke event, its Madical Examiner must be mailted at	2	19a. Informant's Name/Relationship (Typ	a Print)	19h Mailir	ng Address (Street			City or Town, State,	Zip Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic evone.		CHERYL BROOKS (DA			*			MARYLAND	
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П	Pnysician /Medical		23a. Part1 Enter the disease, or complice shock or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Renu	Failu	re				Approximate Interval Between Onset and Death
8760,	To the Hospitel or Attending Physicien: The taw requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Hyper lev Due to (or as a	consequence of):	enosuluri	the Curti	- Evusul	ur Dseub	2 Voyrs
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Ξ	or At after of Direct in by	Certification:	4 Homicide determined	building, etc.	ry - At home, farm, st . (Specify)	reet, ractory, office		City or Town	State)	5/4/ 100t0 114/100t,
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_	J .		Robert C. Dur		101 EF	art tru	e-, 13ul	hmore,	MD 21	230
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 5 2	32. <b>FØ</b> gistra	r's Signature	Carles	•			

t's Name (First, Middle, Last) Solomon Cannan Ir. 2. Date of Death	Please Type or Print in Bla Amend item#1,Uniend item#23a,PII, State of Maryland	ck Indelible Ink. Ensure A 24, penye, 9854, 4/27/06 TI Department of Health and N	Il Copies Are Legible.
	rar	Certificate of Death	Reg. No.
, , , , , , , , , , , , , , , , , , , ,	t's Name (First, Middle, Last) Solomon Cannan, Jr <del>SOLOMON C C</del> A	ANNON, JR	2. Date of Death Month Day Year March 19, 2006

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Baltimore City

111 Penn Street Baltimore, Maryland 21201

4c. County of Death

n/a

3:43 A

Physician
/Medical
Examiner

1. Deceden

4a. Facility Name (If not institution, give street and number)

Mercy Hospital

**Funeral** Director

Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiens. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other treumatic event, Ira Madical Examinar mast be notified at once. Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

Medical Certification; To Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

5. Social Security N	lumber	6. Sex		Age (In yrs.	last birthday)		or 1 Year		24 Hrs. Min.	8. Date of Bir (Month, Da	th Vear		9. Birthplac	e (State or Foreign
220-74	-5355	1 🗆 🗶	2 🗆 F	4	7 Yrs.	Months	Days	Hours	Muri,		2, 195	58	Country	md
Usual Residence of	Decedent					1		1		iviay	_,	,		
10a. State	10b. County	/		10c. Cit	y, Town or Lo	ocation							10d	. Inside City Limits
MD							ВА	LTIMO	RE					1 ☐ Yes 2 ☐ No
10e. Street and Nur	mber					10f. Z	ip Code				10g. Cit	izen of W	hat Country	?
225 NOR	TH SILVE	ER .						21	231				U.S.A.	
44 Marital Ctatus		12 V	Vac Docod	ent Ever in U	C 12	Was Doo	adopt of H			acity Van or No		14. Race - American Indian,		
11. Marital Status		A	rmed Force	es?	.3.	If Yes, sp	ecify Cuba	an, Mexica	n, Puerto	pecify Yes or No Rican, etc.)	,-	Black, White, etc.		
1 Xiever Marri		. 11	☐Yes 2 Yes, Give		1 ☐ Yes 2 ☐ XNo Specify:						ŀ	Specify:	DI	ack
3 Widowed	4 U Divorce	d Y	ear or Dat	es:									DI	ack
(Snec	15. Deceder cify only highe	nt's Educatio			16a. Dece	dent's Us	ual Docup	ation	st of worl	16b. Kind of Bus			siness/Indus	stry
Elementary/Seco			ollege (1-4	for 5+)	life.	DO NOT	use retired	during mo		3				
UKN	, , ,		3- (	,	UKN						UKI	3		
17. Father's Name	(First, Middle,	, Last)						18. Moth	er's Nam	ne (First, Middle	, Maiden	Sumame	e)	
	SOLO	MON C	ANNO	١						BEAT	RICE	HOPK	KINS	
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij											State Zin C	ndo)		
BEATRICE HOPKINS Mother 225 NORTH SILVER COURT BALTIMORE, MD. 21231												ode)		
20a. Method of Disposition  1 Paurial 2 Cremation 3 Removal from State										Date	20c. Lo	ocation - (	City or Towr	, State
1 ∟/Burial 2 4 □ Donation			val from Si	ate	,	CEME	´ I		03/24/06		BAL	TIMORI	E, MD	
21. Signature of Fu	neral ervice	Licensee	. /.	-	2. Name a	and Addre	ss of Facil	lity						
116	Uhm	not	0,000	Marine environment						Chapel P.				
23a. Part1. Enter	H	The same of the sa	no that no	road the deet	b. Do ast sa					ay Baltimor		ıryland		pproximate
shock, of hea	int failure. Lis	t only one ca	use on ea	ch line.	n. Do not en	ter the mo	ae or ayın	ig, such a	s cardiac	or respiratory a	rrest,		l Ir	iterval Between
Immediate Cause disease or condition	(Final	1	Pneumor	nia										nset and Death
resulting in death)		a		r as a conseq	uence of):								_	
			,		, .									
Sequentially list co if any, leading to in cause. Enter Under	nditions,	b. —	Due to (o	r as a conseq	neuce of).								_	
cause. Enter Under Cause (Disease or	orlying _	< −	,											
that initiated events resulting in death)	s ´	c	D 1- /-											
			Due to (o	r as a conseq	uence or);									
		d												
		1											<u> </u>	,
IF FEMALE: 23b. Was deceden	t preamant	23c. li	f yes, outco	ome of pregna	ancy							23d. Date	of delivery	
in the past 12	months?	1	Live bir	th 2 ☐ Feta nt at time of d	death 3		pregnancy	,				Mon		ay Year
1 ☐ Yes 2 [ 9 ☐ Unknown			Unknov		194111 31	Other (	sресіту) <u> </u>							
Part II. Other signif			-		ulting in the t	ınderlying	cause giv	en in Part	I.	10			ibute to the	cause of death?
HIV in	nfection	; Diabet	tes me	llitus		_				10	Yes 2	□No	3 Probab	ly 4 ∭Unknown
										24a. Was	an	24h W	Vere autons	y findings available
				-						auto		p	rior to comp	letion of cause of
										1 X Yes			Y Yes 2	□No
25. Was case refer examiner?	rred to medica	al						26. Plac	e of Dea	th Check only	one)			
1√2 Yes 2□	patient 2 🔯	ER/Dutpatie	nt 3 🗆 C	Oth Oth	er: 4□ N	lursing H	ome 5 Res	idence	6 □Othe	r (Specify)				
27. Manner of Death 28a. Date of Injury						of	28c. Injur Wor			28d. Describe				
1 Natural 5 Pending (Month, Day Year) Inji 2 ∩ Accident Investigation						м		k? Yes 2.[	1No		5555.55 from migary occurred			
3 Suicide 6 Could not be										28f. Location (Street and Number or Rural Route Number				Pauta Numb
4 Homicide  4 Homicide  4 Second fining and determined  4 Second fining at the second fining							огу, опісе			City or To			or murai F	NUMBER,
29a. Certifier (Check only	1 Certifyi	ing Physicie	On the bo	est of my kno	wledge, dea	th occurre	d at the tir	ne, date a	nd place	, and due to the	cause(s	and mar	nner as stat	ed.
one)	- Lymoute	· CAGHIIII of :	and manne	er stated.	ilion and/of if	ivestigatio	лı, ят my o	pinion, de	atri occu	rred at the time,	, date an	u piace, a	ina aue to th	ie cause(s)
29b. Signature and	title of certifi	er				29c. License number 29d. Date signed (Month, Day, Year)				iy, Year)				
1 his	hi	, v	an				OCME					March 19, 2006		
,	_	,	my				OCI	YLL'		March 19, 2006				

State

Registrar

LING 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

APR 0 5 2006

Registrar's Signatute

			For Amend Trem 20h	rpe or Print in State of Messyla	ing/Proparto	ent of Hea	Ith and N		_	101.17
			1 - State Registrar		Certific	cate of De	ath	R	leg. No.	1041/
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  BERNARD		CRum.	PJR		2. Date of Dea Month March	Day Year 31 200	3. Time of Death 6 2:08 P M
	Examin		4a. Facility Name (If not institution, give st	reet and number)		City, Town, or Loc	ation of Death		4c. County of Dea	th
				ing Hvenue		altimo			N/	4
A second	Funeral Director		218-60-4021	7. Age (In yi			Under 24 Hrs. ours Min.	8. Date of Birth (Month, Day Nay 28)	(, Year)	thplace (State or Foreign ountry)
	pu		Usual Residence of Decedent  10a, State 10b, County	100	City, Town or Location	1				10d. Inside City Limits
	aryla eho	'n			_	_	- 1000	DT 11	-:/	1.XYes 2 □ No
	he N	Director	MYHKI/LAND N/	A		BALT f. Zip Code	11701		10g. Citizen of What Co	nuntry?
	death with the Maryland	급	4716 GREENS	Convide Au	BOTTH	Lip oodo	2130	9	//<	7
	eath	era		2. Was Decedent Ever in	U.S. 13. Was [	Decedent of Hispar , specify Cuban, M	nic Origin? (Sr	pecify Yes or No-	14. Race - Ame	erican Indian,
•	r iten	Funeral	1 □ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				o Rican, etc.)		te, etc.
200	ursaft and, or Exemi	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	14	es 22 No S	pecify:		Specify: BL	ACK
5-0036	72 hours after natural', or Ite	Completed	15. Decedent's Educa (Specify only highest grade		16a. Decedent's	Usual Occupation of work done durin	n most of work	kina	16b. Kind of Business	/Industry
2	within iene. then "then the	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO N	OT use retired)		)	D	0 1
2	led w lygier her th	S	10 TH GRADE		F200.	R TECI			15 14 LTO . ( Maiden Sumame)	COUNTY
ב	be fill htal H bd ott	Be	17. Father's Name (First, Middle, Last)	an.	0	1	4 4			0.05
2	should nd Men marke	<sup>2</sup>	DERNARD  19a. Informant's Name/Relationship (Typ)		IMP SK		MATT		r, City or Town, State,	TID CODE
Maryland	d 2 st h and 7 le n traun		CAMILLA CRUMP	(WIPE)		GREENS			**	D. HD. 21209
	theall tem 2		20a. Method of Disposition	The state of the s	ms 4 ms 54		FRING	Date	20c. Location - City or	
<u>o</u>	00		1X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	CINC ery, cremator	y or other place)	04-1	27-01	WOODLAN	
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee		22. Nar	ne and Address of	Facility 2/4	40 N. FU	HON AVE. 1	113 21217
B	permit Depart Import any in		District N	Willian					ral Home	
	***************************************		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the de						Approximate Interval Between
	Physician		Immediate Cause (Final	and the second s	guinati	nn				Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cons	equence of):	,				
*	Examiner		Sequentially list conditions	Antic	oagula	tion				
122	D ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons						
	ecute and trans	Examiner	that initiated events c. resulting in death) Last	Periphe Due to (or as a cons	wal Ar	terial	Dise	ease		
60,	be executed icien and burial-transil	cal E)		Due to (or as a cons	equence on.					
687	ficate be executed physicien and is the burial-transit	dica	d.							
×	leath certificate attending phys I for use as the	/Me	IF FEMALE: 23	c. If yes, outcome of pre-					23d. Date of de	livery
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		pic pregnancy er (specify)			Month	Day Year
О	t the c by the achec	Physician/Medi	9 Unknown	9□ Unknown						
ώ.	The law requires that the death certificate ite has been signed by the attending phys bage 2 should be detached for use as the	by P	Part II. Other significant conditions cont			ying cause given in	n Part I.	23e. Did to	obacco use contribute t	
ğ	w require been sig should b	ed			sease			1 🗆 ነ	res 2□No 3□P	robably 4 🖾 Onknown
000	law re as be 2 sho	pie	Dinbetes N	rellitus				24a. Was autop	an 24b. Were a	utopsy findings available completion of cause of
Œ.	The ate h	Completed	Cerebrovasi	inlar D	isease	4.		perfo	rmed? death?	s 250 No
<u>ta</u>	cian: ertific octor,	Be (	25. Was case referred to medical examiner?				. Place of Dea	th (Check only o	ge)	
7	hysio this c	2	1 165 2 40		ER/Outpatient 3		4 Nursing H		dence 6 Other (Spe	ecify)
n	ling F	ion	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	29b. Time of Injury	28c. Injury at Work?	2 🗆 No	280. Describe r	now injury occurred	
Division of Vital Records,	death death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A			2010	28f. Location (S	Street and Number or F	Rural Route Number.
<u>≥</u>	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	asiony, omico		City or Tov		
	spita nours neraf filled			cian: To the best of my l						
	n 24 I n 24 I he Fu pletel	Medicai	(Check only 2 Medical Examin one)	er: On the basis of exam and manner stated.	ination and/or investig	gation, in my opinic	on, death occu			
	To t To t	Σ	29b. Signature and title of certifier	1-01-	han	29c. License nu			29d. Date signed (Mor	1
•	n		Muner	,	MD	L	577	_	04/05	2006
	7		30. Name and address of person who cor Deena Ebria	npleted cause of death (I	3333 N	Calver	+ 5+.	# 655	B, Balt	, MD 21218
	Sta Registi		31. Date filed (Month, Day, Year)  APR 9 5 2006	33. Registrar's Si	gnature M Angelli					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend ItemsState of Manyland / Department of Health and Mental Hygiene Per Dr. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0813 AM Joseph كالانك /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NIA , Shock Trauma Univ. MD Med Ctr 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**]M 2□F 219-40-4892 62 Director November 23,1943 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland Worcester Berlin 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itams 23s or 11003 Grays Corner Road 21811 USA filed within 72 hours after deeth Funeral Was Decedent Ever in U.S. Amed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐Yes 20 No Yes, Give 1 Never Married 2 ☐ Married Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) I Hygiene. Steel 7 years Millrite permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic avant, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marie Sophia Polityva Charles Wesley Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Dueling Way, Berlin, Maryland 21811 sister Connie Bohager Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State March 20, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cardens of Faith Cemetery Rosedale, Maryland 2006 21. Signature of Funeral Service Licenses <sup>22. Name and Address of Facility</sup> Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease or complications that caused the death. Of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Jist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracranial henurhage /Medical Due to (or as a consequence of): Examiner Hypertension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialphysicien P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 27/38a-2Division of Vital Records, 2 icate hes been sig cerebral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: patient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) f**⊈**Yes Certification: To 2 🗆 No After this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? deeth. TOWARD COWN investigation 1 Yes 2 No 2 Accident s efter deeth 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Gity or Town, State) ģ 4 Homicide ni bellii To the Hospital within 24 hours e To the Funarel C completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and itle of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30. Name and add\_ss | f pe on who completed cause of death (Item 23a) (Ty e, Print) D0063044 3117106

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0

5 2006

				State	of Marylai		artment <i>rtificate</i>			Mental Hy	/giene Reg. No. () (	16	10419	)
			1. Decedent's Name (First, M	iddle, Last)						2. Date of De	eth Day	Year	3. Time of Death	1
	Physici /Medi		Mary D. Candi	Leana						March			3:34 PM	
	Examir		4a. Fecility Neme (If not instit	ution, give street and	number)			- 4	4b. City, Town, or	Location of Deat	th 4c. County	of Death		
			9440 Riverbri	ink Court					Laure	1	Hov	vard		
Ī	Funeral		5. Social Security Number	6. Sex		. last birthday)	If Under Months	1 Year Days	If Under 24 Hr Hours Mir		rth	9. Birthpi	lace (Stete or Forei	ign
	Director		214-16-1854	1□M 2∏F	8	4 Yrs.	WOITIS	Days	Tiouis Will	Mar 4,	1922		land	
	pu ,		Usual Residence of Deceden		140-0									
	anylar shov	_	10a. State 10b. Cou	•	10c. C	ity, Town or Lo						10	0d. Inside City Limi	
	Ba-f	5		ure1		Howan	rd						1 □ Yes 2√ N	10
	in the	ä	10e. Street end Number				10f. Zip				10g. Citizen of \		try?	
	ath w	Funeral Director	9440 Riverbr						20723		USA			
	ema Fr	au a	11. Marital Status	12. Was De Amped	ecedent Ever in U Forces?	J,S. 13. \	Was Decede f Yes, speci	ent of Hi ify Cuba	ispanic Origin? ( an, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Red Blad	e - America ck, White, e		
20	afte s	by F	1 Never Married 2 1	If Yes,	s 2□No Give 144 Dates: 144	İ	1□Yes 2		Specify:		Specify		ite	
21215-0020	filed within 72 hours after death with the Maryland Hygiene. ther than "netural", or items 23e or 28a-f show that the Medical Examiner must be notified at	P P	3 X Widowed 4 □ Divor		Dates: 44									
5	"net	Completed	15. Dece (Specify only high	dent's Educetion ghest grede complete	d)	16a. Deced	dent's Usual	k done	ation during most of wo f)	orking	16b. Kind of B	usiness/Ind	ustry	
12	withii sne.	ğ	Elementary/Secondary (0-1	2) College	(1-4or 5+)						h 1 + h			
2	Hygie ther int,		17. Father's Name (First, Midd	dle ( ast)	·	<b>L</b>	egist	ELEC	1 nurse	me (First, Middle	health			
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene.  If item 27 is marked other than "netural", or items 23e or 28e-f show or other treumatic event, the Madical Examiner must be notified at	Be	Ray Augustin							Catherin		•		
$\overline{\mathbf{z}}$	hould d Me mark matic	P	19a. Informant's Name/Relati			10h Mailie	a Address	/Stroot		tural Route Numb			0-4-1	
Ma	d2s than 7 is r		Michael K. Ca		an .				Road Bov			State, Zip	Coae)	
e)	Health Health Iem 27 i		20a. Method of Disposition	ilurealia/ Sc		Place of Dispo			Road Dov	Date	20715 20c. Location -	City or Tox	um State	_
Baltimore,	Pages nent of ant: If it ury or o		1 ☐ Burial 2 ☐ Cremati 4 🂢 Donation 5 ☐ Othe		m State	cemetery, cren	netory or oth	her plac	e)			J., J	THI OTHER	
Balt	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any Injury or other tre once.		21. Signal in of Peral Service Ron 11 co	S. Wade	Directo	T.	Name and tate A			d 655 W	. Baltim	ore S	treet	
			23a. Parti. Enter the disease	, or complications tha	t caused the dea						rrest,		Approximate	_
1	Physician		shock or heart failure.	list only one cause or	i each line.								Interval Between Onset and Death	
1	/Medical		Immediate Ceuse (Final disease or condition	mot	ostotio	coatri						0		
	Examiner		resulting in death)	a. mec.	astatic Due to (	or es e conseq		LEI				10	months	
	D #	ner			,		,							
	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions,	<b>f</b> b.	Due to (c	or as a conseq	uerice of).							
Ö,	e exe ian a unial-	m	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	J								i		
68760,	ate b hysic the b	edicai	that initiated events resulting in death) Last	C.	Due to (c	or as a consequ	uence of):				٩	+		
	ng pl	-	<b>3</b> ,	L.								1		
Вох	leath cert attending I for use a	an/		d								-		
	e dea he at	Sic	Part II. Other significant cond	litions contributing to	death but not res	sulting in the ur	nderlying ca	use give	en in Part I.	23b. Did	tobacco use cor	ntribute to	the cause of death	1?
P.0	thet the de led by the a deteched t	Physician/N								1 🗆	Yes 2 No	3 🗆 Prob	ably 4 🗆 Unknow	wn
Ś	es the igner	۵								-	4			
of Vital Records,	The law requires that the death cer ate has been signed by the attendir page 2 should be deteched for use	Completed									an autopsy rmed?	avei	re autopsy findings ilable prior to	
Ö	as by	흕											pletion of cause eath?	
œ		8								10	Yes 2 No	1 🗆	Yes 2□ No	
/ita	Physician: Th rthis certificate ral director, pa	Be	25. Wes case referred to med examiner?	ical						eth (Check only o	one)			
Ž	hysic nis ce	ဥ	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3□ DOA	Othe	er: 4□ Nursing I	dome 5 Resid	dence 6 □Othe	er (Specify)	1	
	Jing Ph h. After th funeral	ü	27. Manner of Death 1 ■ Per		e of Injury onth, Dey Year)	28b. Time of Injury	28	c. Injury Work	at c?	28d. Describe	how injury occurr	ed		
Sio	Attending ir death. actor: After by the fune	äţ	2-1 Accident inve	stigation			М		Yes 2□No					
Division	or Attend efter death Director: / d in by the f	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide deta	ld not be ermined 28e. Plan buil	ce of Injury - At hoding, etc." (Specif	ome, farm, stre	et, factory,	office		28f. Location (3 City or Tox	Street and Numbern, Stete)	er or Rural	Route Number,	
	ital c ral Di ral Di													
	To the Hospital or A within 24 hours efter To the Funeral Director Completely filled in b	edicai	29a. Certifier 1 Certific (Check only one)	ying Physician: To the and ma	ne best of my kno basis of examine inner stated.	wledge, death tion end/or inv	occurred at estigation, i	t the tim	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and ma date and place, e	nner as ste and due to t	ited. the cause(s)	
	o the	Me	29b. Signature and title of cert	//-/			29c.	License	number		29d. Date signed	(Month, D	ley, Yeer)	
<b>N</b>	P > F 0		► 1//// K	buch	MAIS		т	0 08	75/		Morah 1/	200	)6	
		-	30. Name end address of pers	on who completed as	use of death /Item	n 23a) /Time !		00	1734		March 14	, ZUL	70	
	6		Thomas Bensin	/	,			Suit	e 205 G	reenbelt	. MD 207	'70		
	Sta	te	31. Date filed (Month, Day, Ye		gistrer's Signa						, 110 201	, 0		
	Registra		APR 0	5 2006	108.00 m	K K	2000							

State of Maryland / Department of Health and Mental Hygiene

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			l = State Registrar			Cei	tifica	te of l	Death			Reg. No.		
			1. Decedent's Name (First, Middle, Las	st)							2. Date of De		Year	3. Time of Death
Me Jo	Physicia		FRANCES	EMILY SIM	MS (	CORN					Month April	3 ,	2006	8:45 a M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City	, Town, or	Location	of Death		4c. Cour	nty of Death	1
100		21.	Laurel Regional H	ospital			La	urel				Pri	nce G	eorge's
	Funeral	· 6	5. Social Security Number 6. Sec		(In yrs. la	st birthday)		r 1 Year	If Under		8. Date of Bir	th Voor	9. Birth	nplace (State or Foreign
100	Director		314-26-0897	□M 2□F	76	Yrs.	Months	Days	Hours	Min.	Month, Da June 28	1929	Inc	diana
	D		Usuat Residence of Decedent											
	ylan how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
	Ma	ţo	Maryland Prince	George's	Lau	ırel								1. Yes 2 No
	r 28	<u>e</u>	10e. Street and Number				10f. Z	p Code				10g. Citizen o	of What Cou	ıntry?
	h wit	<u>=</u>	1022 Montrose Ave	nue				207	07			U.S.A		
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show tha Modical Examiner must be nutillian at	by Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S	. 13.	Vas Dec	edent of H	ispanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	)- 14. F	lace - Ameri	
9	after or ite	3	1 Never Married 2 Married	1 ☐ Yes 2 🛛 Mo	)			2 <b>X</b> IX/o	Specify:		riidari, etc.)		llack, White	
පු	raif, c		3 Widowed 4 Divorced	Year or Dates:			I LI Tes	2 MIVNO	зреспу.			Spe	cify:Whi	te
21215-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest gra	fucation de completed)		16a. Deced	dent's Usi	al Occup	ation	t of worki	na	16b. Kind of	Business/Ir	ndustry
2	Mac Phi	pid	Elementary/Secondary (0-12)	Coltege (1-4or 5+	)				during mos f)		9	_		
2	erth Ban	ő	Grade 12			Bank	Tel	ler				Bank		
9	al Hy loth vent	Be (	17. Father's Name (First, Middle, Last)						18. Mothe	er's Name	(First, Middle	, Maiden Sum	ame)	
a	vid b Ment Ment rrked rrked	2	John Wesley Owen	Simms					Emma	Eli:	za Robb	ins		
Maryland	sma smu		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	g Addres	s (Street	and Numbe	er or Rura	i Route Numb	er, City or Tov	vn, State, Zi	ip Code)
Σ	alth alth		Sharon Harmon /	daughter		2852	Jess	up Ro	oad	Jessi	up, Mar	yland	2079	4
re	iter oth		20a. Method of Disposition		20b. Pla	ice of Dispo	sition (Na	me of other plac	(e)		Date	20c. Locatio	n - City or T	Town, State
Ĕ	Page ent c nt: if ry or		1 ☐ Burial 2 XX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi			Arun	-			4/5	/2006	0den	ton, 1	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nutified at once.		21. Signature of Funeral Service Licen	see		22	. Name-	and Addre	ssof Facili	¥-1 1	Home, F	7.		
Ä	P S T E S		1 6756	/ M	00770	) 3	13 T	albo	tt Av	enue	Laure	l, Mar	yland	20707
* 5			23a. Part1. Enter the disease, or com	plications that caused t	he death.	Do not ent	er the mo	de of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Discourie in the		shock, or heart failure. List only Immediate Cause (Final	1										Onset and Death
)	Physician /Medical		disease or condition resulting in death)	Respiration Due to (or as a			re							2 days
ÿ.	Examiner			COPD	conseque	siice 01).								20 years
		-	Sequentially list conditions,	b. Oue to (or se a	eoneguk	aride offy								1
W	nsit	Examiner	Sequentially tist conditions, if any, leading to instructions cause. Enter Underlying Cause (Disease or injury	Tobacco	IIco									years
5	xecu and ai-tra	xai	that initiated events resulting in death) Last	Due to (or as a		ence of):								years
9	be e sicier buris													
68760,	certificate be executed Iding physicien and Ise as the burial-transit	/Medical		_ d										
XO	certii nding ise a	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o								23d.	Date of deliv	verv
m	death	ciar	in the past 12 months?	1□Live birth 2 4□Pregnant at ti			Ectopic   Other (s	pregnancy pecify)					Month	Day Year
o.	the d y the	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			· ·							
<u>α</u>	w requires that the death been signed by the atter should be detached for u	by Physicia	Part It. Other significant conditions of	ontributing to death but	not resul	ting in the u	nderlying	cause giv	en in Part I	l.	23e. Did	tobacco use co	ontribute to	the cause of death?
ds,	uires Isigr Id be		Dementia								XX	Yes 2 □ No	3 ☐ Pro	obably 4 DUnknown
Ö	v req beer shou	Completed									24a. Was	an 24	h Were au	topsy findings available
ĕ	The law ate hes b bage 2 sl	m d									auto	DSV	prior to o death?	completion of cause of
9	r: Th											ormed? 2 No	1 🗆 Yes	2×40
Ž.	iciar certif ecto	Be	25. Was case referred to medical examiner?	Hospitat:				OA Oth	Or.		(Check only			
ŏ	Phys this aldii	To	1 ☐ Yes 2 No  27. Manner of Death	XXnpatien		R/Outpatier 28b. Time o			4 🗆 140		me 5 Res			eify)
	Attending Physician: r death. ector: After this certific by the funeral director.	ion	1 XXatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	Injury	М	28c. Injur Wor	k?" Yes 2□		200. Describe	now injury occ	direc	
Sic	tend Jeath tor: the	cat	2 Accident investigation 3 Suicide 6 Could not be						165 2	1140	29f Location	Street and Nu	mhor or Bu	ral Route Number,
Division of Vital Record	or A after Direc in by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	ne, iarm, su	eet, lacto	ry, onice				wn, State)	noer or Au	rai noble ivaliber,
_	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of	mu lene:	dodgo do-ti		d at the fire	no deta	nd place	and due to the	001100/0\ 05-1	mannar	ctated
	Hos 24 hc Fun tely	edical	(Check only 2 Medical Exam	niner: On the basis of and manner state	examınatı	on and/or in	vestigatio	n, in my o	pinion, dea	ath occurr	ed at the time,	date and plac	e, and due	to the cause(s)
	To the within 2. To the Complet	Med	29b. Signature and title of certifier	and mariner state	ou.		2	9c. Licens	e number	<del></del> -		29d. Date sig	ned (Monti	n, Day, Year)
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	$\int \int $		1 / mmy //	1 you		<u>/</u>	- L	<u>y</u> .	///	-) (		1/2	100	7
	'ٲ`		30. Name and address of person who Timothy McClain,					Str	eet	Laur	el, Mar	yland	2070	7
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 2	32. Registra	r's Signati	ire A	seek.	,						

			State of Manuford / Department of Health and Mantal Hydiana
			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrer  State of Maryland / Department of Health and Mental Hygiene  Certificate of Death
			Reg. No.  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
	Physici	an	Month, Day Year
	/Medic		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examin	er	HOME 114W Clement St Baltimore NA
	Funeral		5 Social Security Number 6 Sex 7 Age (In vrs. (ast hirthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9 Birthplace (State or Foreign
	Funeral Director		217-16-5908 18M 2 F 82 Yrs. Months Days Hours Min. (Month, Day, Year) Reunity) and Maryland
			Usual Residence of Decedent
	thow	_	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Ba-f s	cto	Maryland n/a Baltimore 1™Yes 2□No
	ath with the Marylan 123e or 28a-f show	Dire	106. Street and Number  107. Zip Code  108. Clement Street  108. Clement Street  109. Citizen of What Country? United States
	72 hours after death with the Maryland naturel; or Items 23e or 28e-f show jiest Examiret must be nuffield at	Funeral Director	114 W. Otemene Serece
	ltems	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1 Never Married 2 Married 1 Wes 2 No If Yes, Give Year or Dates: WW II Specify: White
8	d within 72 hours after dea jiene. r then "naturel", or Items the Medical Examinet na	ed	15 Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business/Industry
15	- × 100	plet	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)
212		Completed	6 years
פ	be filed ital Hygi id other event, I	Bec	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)
<u>la</u>		Tof	Arthur A. Carson, Sr. Gertrude Houck
Maryland 21215-0036	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	s 1 and 2 if Health item 27 other tra		Barbara Quoss (daughter) 1219 Weddel Ave. Baltimore, MD 21227
ore	of of		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State
Ĕ	Pa nen ant: ury		MD Veterans Cemetery 4-5-2006 Crownsville, Maryland
Baltimore,	permit. Pag Department Importent: I any injury o		21. Sind tre of Funera Varvice License McCully-Polyniak Funeral HOme, P.A.
_	₫ Q E @ Q	Ш	J. wayne Osterling 130 E. Fort Ave Baltimore, MD 21230
١.			23a. Part. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, list only one cause on each line.  Approximate Interval Between Onset and Death
	Physician		mediate Cause (Final) resolution in death) a End Stage Chronic Obstructive Pulmonary Diperse Years
	/Medical Examiner		Due to (or as consequence of):
		io l	Sequentially list conditions, b. Due to (or as a consequence or).
W	uted Insit	ij	Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events cause).
1	be executed ician and burial-transit	Examiner	resulting in death) Last
760,	0 2 0	cal	d.
99	leath certificate attending physi I for use as the		
Вох	h cer endin	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 23d. Date of delivery
	deat ne att ed for	sicla	in the past 12 months?  1 Pregnant at time of death 5 Other (specify)
P.0	that the de led by the a detached f	hy	9 Unknowp
	Se G	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 RNo 3 Probably 4 Unknown
Records,	w requir been si should	ted	
ec	law las b	nple	Motbul Obesity  24a. Was an autopsy prior to completion of cause of
=======================================		Completed	performed? death?  1 \( \text{Yes} \) 2 \( \text{No} \) 1 \( \text{Yes} \) 2 \( \text{No} \)
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  26. Place of Death (Check only one)
of	S S	2	1
UC	ding Phy h. After thi funeral	lon	11 Matural 5 Pending (Month, Day Year) Injury Work?
Sic	ttendi death. ctor: A y the fu	icat	2 Noticide 6 Could not be
Division	l or Attendater death Director:	Certification:	4 Homicide determined building, etc. (Specify)
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	To the Hospita within 24 hours To the Funerel completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within To the Comp	M	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
•	1		D24149 4/3/06
	vX/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	大`		Dorothy A. Snow, M.D 10 N greene St Balt MD 21201
	Sta		31. Date filed (Month, Day, Year)  32. Regultrar's Signature
	Regist	rar	APR 0 5 2006 Heren It foods

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#25,27,28d, perMF C854-4/5/06 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Leloy W. Month 0.3 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner University of maryland medical Center Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
June 8, 1913 6. Sex 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F 92 213-05-5372 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Mudical Exertinat Legisland and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2X No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 9118 Deviation Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1X/Yes 2 □ No If Yes, Give Year or Dates: WW 11 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Police Department Police Sergeant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Clark Mary Montley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Maude G. Clark 9118 Deviation Road, Baltimore, MD (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parkwood Cemetery 4/6/2006 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Homes Buri a. U 9705 Belair Rd., Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Intar Myocardial days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence ol). Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last ettending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) 4☐Pregnant at time of death the detached 9 Unknown 9 Unknown à s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Certification: To 1 A Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 2 Accident 5 Pending investigation 106 UNKPM 1 ☐ Yes 2 X No fell off step ladder filled in by the 3 Suicide 6 ☐ Could not be Place of Injury · At home, farm, street, lactory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Home 9118 Deviation within 24 hours e Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Wednesd examinate: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) lese, 16643 3/31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e Street Baltimore, in D C.De Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2006 Registrar

December   Carbon				1 - For State Registrar	State of	Marylar				lealth a Death			gien Reg. N	ć U U b	104	23
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Too State   100. Course   10							110.				F	ebuary	28	1929 Was	hingto	on DC
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The control of the co		or 28	jre	10e. Street and Number					ip Code	•			10g. C	itizen of What Cou	intry?	
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20. Method of Disposition 1	<u>a</u>	Venta Venta riked	10	Ashby Peyton						Ju1	ia (	unknov	vn)			
20. Method of Disposition 1	a	and lama						-							p Code)	
State   Stat	_	and ealth m 27			on					Takon						
23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	9	or off		,	☐Removal from St		Place of Dispo cemetery, crea	osition (N matory or	ame of other plac	(e)				•		
23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.		tant:		4 □Donation 5 □ Other (Special	(ty)					atory	7				va ———	
23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	g	Depar Tipor		21. Signature of Funeral Service Lice	nsee	_	22	2. Name : 6 1 7	Ind Addres	ss of Facilit	Pope	Funera	11 F	Home		
Abok of heart failure. List only one eause on each line.    Immediate Causes (Final resulting in death)   20 to [or as a consequence of]:   20	_	4024 d		Ellaner	Lax									DC 20020		
FEMALE   23c. If yes, outcome of pregnancy   10 was at decedent pregnant   10 was at decedent pregnant   10 was at decedent pregnant   10 was at decedent pregnant   10 was at 2 months?   10 was 12 months?   10 was 2 months?   10 was 2 months?   10 was 12 months?   10 was 2 mon		/Medical Examiner portion and portial-transit	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (o	r as a consec tes r as a consec	quence of):								Onset and	Death
Composition   Composition	. Box 6	t the death certiff by the attending ached for use es	80 1	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒No	1□Live birt 4□Pregna	th 2 ☐ Feta nt at time of c	aldeath 3			,					•	Year
24a. Whs an autopsy performed? 1   Yes   2   No   25. Was case referred to medical examiner? 2   No   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 3   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 3   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 3   1   Yes   2   No   1   Yes	ıv.	s thai	by P	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the u	nderlying	cause giv	en in Part I		23e. Did t	obacco	use contribute to	the cause of	death?
24a. Whs an autopsy performed? 1   Yes   2   No   25. Was case referred to medical examiner? 2   No   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 3   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 3   1   Yes   2   No   1   Yes   2   No   25. Was case referred to medical examiner? 3   1   Yes   2   No   1   Yes	ğ	aquire en sig	ed									10	Yes :	2 <sub>2</sub> ∏No 3∏Pro	bably 4 🗆	Unknown
25. Was case referred to medical examiner:    25. Was case referred to medical examiner:   1	ပ္ထ		ple											24b. Were aut	opsy findings	available
25. Was case referred to medical examiner:    25. Was case referred to medical examiner:   1	r,	The ate h pege	ρ.									perfo	rmed?	death?		
27. Manner of Death   1	<u> </u>	cian: ertific ector,	Be	25. Was case referred to medical examiner?							of Death	Check only o				
1 Natural 2 Accident 3   Suicide 4   Homicide   See Place of Injury - At home, farm, street, factory, office   28t. Location (Street and Number or Rural Route Number, building, etc. (Specify)		hysi this c			1 L In										hy) Hosp	ice
29a. Certifier (Check orily one)  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan 6001 Muncuster Mill Rockville MD 20855  31. Date filed (Month, Day, Year)  32. Registrar's Signature		ling After une	<u>o</u>	1 ☑ Natural 5 ☐ Pending		Day Year)						d. Describe I	how inj	ury occurred		
29a. Certifier (Check orily one)  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan 6001 Muncuster Mill Rockville MD 20855  31. Date filed (Month, Day, Year)  32. Registrar's Signature	<u>s</u>	ttend death tor: the f	icat	3 ☐ Suicide 6 ☐ Could not t	00 00 0	d Injune . At h	nome form at			Tes 2 🗆		of Logation (	Ctroot	and Number or Du	rol Courte Nue	-hor
29a. Certiflier (Check only one)  29a. Certiflier (Check only one)  29a. Certiflier (Check only one)  29b. Signature and title of certiflier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan 6001 Muncuster Mill Rockville MD 20855  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature	<u>≥</u>	after Direction by	ertif	4 Homicide determined	building	g, etc. (Speci	fy)	reet, racti	ry, onice		20				ar Houle Nur	TDBI,
D35635  April 3, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan 6001 Muncuster Mill Rockville MD 20855  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature		papite hours ineral		(Check only 2 Medical Exa	miner: On the bas	is of examina	owledge, deat ation and/or in	h occurre	d at the tin	ne, date an pinion, dea	id place, ar	nd due to the d at the time,	cause( date a	s) and manner as nd place, and due	stated. to the cause(	s)
D35635  April 3, 2006  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Joseph Kaplan 6001 Muncuster Mill Rockville MD 20855  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature			Me					2	9c. Licens	e number			29d. D	ate signed (Month	Day, Year)	
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DHMH 17 Rev 1/2001

ORIGINAL

•		For State gistrar	,	•	tificate of	Health and Death		Re	eg No.	5 101
Physician		Decedent's Name (First, Midd	dle,Last)				2	Date of Deat Month	Day Year	3 Time of Death 8:16AM
lical Examine		Richard Al				th City Town or La	ention of Dooth	April 2, 20	4c. County of De	
}	48	a. Facility Name (if not institution 19310 Club House Diego 19310		number)	-	b. City, Town, or Lo  Montgomery			Montgomer	
Funeral	5.	Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year		8. Date of Bir	th (MM/DD/YYYY) 9	Birthplace (State or
Director		367-30-5149	1 X M 2 F	7/	Yrs	Months Days	Hours Min.	12/19	/1931 <sub>N</sub>	Country) Iichigan
		sual Residence of Decedent	122 101 2		113					-2
any		a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City
nd show	_ M	aryland Mont	gomery	Mont	gomery	Village				1 X Yes 2
the Maryland a or 28a-f sh liffed at once	ည် 10	e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	country?
the Man or 2	5 :	19310 Club Hou	ise Road			20886			United Sta	ates
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Commissed by Eumoral Director	11 Je 11	. Marital Status  Never Married 2 N	Married Armed	ecedent Ever in U.S Forces?	S. 13. Wa	s Decedent of Hispa es, specify Cuban, t	anic Origin? ( Spe Mexican, Puerto F	cify Yes or No tican, etc.)	- 14. Race - Ar White, etc	merican Indian, 81ad c.
er de:		X Widowed 4 Di	1 X Yes ivorced If Yes, Give Y	ear Korean .	1	Yes 2 X No	specify:		Specify:	White
urali mine	<u>`</u>	15. Decedent's Education (Spe	or Dates:	Conflic		t's Usual Occupation		ork done	16b. Kind of 8usine	ss/Industry
2 hou	oeie	Elementary/Secondary (0-12)			during most of	working life. DO NO	T use retired)			
og6	ka pajaidwon		5+			Architec			Federal	Governmen
5-01 led wi Hygier other	3 17	7. Father's Name (First, Middle	e, Last)				3.Mother's Name (			
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	n D	Roy Cumming					Jane E.			
hould hould and Mer is man	0 19	a. Informant's Name/Relation:							mber, City or Town, S	
MD and 2 sho allth and m 27 is aumati		Susan J. Jones	s/daughte			Cornflow		_		841
S ar of Hea If ites		Da. Method of Disposition  X 8urial 2 Cremation	on 3 Removal		Place of Dispos crematory or otl	ition (Name of ceme ner place)	Apri	L1 5,	20c. Location - City	
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		Donation 5 Other S	_		e of Hea	ven Cemeter	_		Silver S	pring, Man
alti mit. partm ports		Signature of Funeral Service			22 B	lame and Address of	of Facility Threy Fund	eral Hom	e, Rockville	e, Inc.
		Milliam a. 7	Knymey	M0117	73   300	W. Montgo	mery Aven	ue, Rocl	cville, MD	20850
Physician	23	Ba. Part I. Enter the disease, o failure. List only one cause		caused the death.	Do not enter to	ne mode of dying, so	uch as cardiac or	respiratory arr	est, shock, or heart	Approximate Between Ons
/Medical Examiner		nmediate Cause (Final diseas	e a Atheros	clerotic ca	ardiovaso	ular diseas	se			Death
	0	r condition resulting in death)	540 (0) (4)	s a consequence of	F):					
		equentially list conditions, any, leading to immediate	b. Due to (or as	s a consequence of	f):					
	~	ause. Enter Underlying Cause								
	E (						-			
sit sd /	xamir e	Disease or injury that initiated vents resulting in death) Last	Due to (or as	s a consequence of	f):		,			
ecuted and transit	al Exam e	Disease or injury that initiated vents resulting in death) Last	Due to (or as		f):					
0, be executed sician and burial - transit	<del>-</del>	Disease or injury that initiated vents resulting in death) Last	d. AMENDE	item# 23	3a, 27, <sub>I</sub>	erME, G854,	, 4/10/06	rt		
ficate be executed g physician and s the burial - transit	<del>-</del>	Disease or injury that initiated vents resulting in death) Last VIPENDED  FEMALE: b. Was decedent pregnant in	d.  AMENDEL  23c. If yes	item# 23	Ba, 27, p				23d. Date of del Month	ivery Day Ye
certificate be executed ending physician and use as the burial - transit	<del>-</del>	Disease or injury that initiated vents resulting in death) Last  X UNPENDED  FEMALE:	Due to (or as d.  AMENDEL  23c. If yes 1 Live	item# 23	3a, 27, p	perME, G854,	, 4/10/06			-
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April **Physician** 2, 2006 June Washburn Creamer 5:14 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10014 Montauk Avenue Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1□M 2XF Months Days Hours 103-24-3746 76 Yrs. June 1, Director 1929 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Examiner must be notified a 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.
Importent: if Item 27 is marked other then "natural", or Items 23a or 2 and hjury or other traumatic event, the Madical Examiner must be na once. 10014 Montauk Avenue 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Assistant Treasurers 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Credit Union Office Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clair Washburn Althea Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doreen C. Bruder/Daughter 6012 Griffith Road, Laytonsville, Maryland 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 5. t Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Zion Cemetery Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service-Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Ungala teloma w M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Inner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure Four Years /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Sequentially its conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 🗆 Yes 2 🖾 No Month Year 4□Pregnant at time of death 5 Other (specify) P.O. I ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 X Yes 2 No 3 Probably 4 Unknown Completed peen s 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

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Neral Director: After this certificatilled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 \$\overline{\Delta}\$ Residence 6 Other (Specify) ٩ 1 ☐ Yes 2X No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Injury 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Dey, Year) Michael a. Wetterman D52451 April 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O.Box 2316, Kensington, Maryland 20891 Michael A. Westerman, M.D. 31. Date filed (Month, Day, Year) State Registrar APR 0 5 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death APRIL **Physician** CUMLEY DEBRA 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE HOSPICE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Y)
MAR 21 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 202 F 50 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WEST CHESTER CHESTER 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö RICKLEWOOD U5B Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 □ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: δ WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GRAPHIC INTERIOR DESIGNER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ( permit Pages 1 end 2 should be Department of Health and Mental Important: If Itam 27 is marked 4 any injury or other traumatic avenage. ROBERT CUMLE HELEN ATKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Gode) 1165756 19a. Informant's Name/Relationship (Type, Print) JAMES T. CRISPINO (HUSBAND) CRICELEWOOD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2. Cremation 3 Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 7250 WASHINGTON BLVD ELKEIDGE MD 21075 23a. Part1. En # the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 20 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ၉ Diractor: After the 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) i mo pleted cause of Jea h (Item 23a) (Type, Print) Charles St. Balfo, and 2120x 5-3 mc 31. Date filed (Month, Day, Year) State APR 0 5 2006 Registrar

				State of Mary					_	10107
		•	1 - For State Registrar	,		rtificate of			g. No.	10461
	Dhysisi		1. Decedent's Name (First, Middle, Las	<i>t</i> )				2. Date of Death Month	Day Year	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution, give		a 1 1	_ **	r Location of Death	1	4c. County of Deat	
				one Medical  7. Age (In	yrs. last birthday)	Balkin If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	Baltimare	
г	Funeral Director			□M 2QF	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplece (State or Foreign buntry)  'yland
			Usual Residence of Decedent	- 63				Sept.22	, 1942	
	show	_	10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Ba-f s	Directo	Maryland   Anne Ar	undel G	Slen Burr			46	- Oiri 1111 O-	
	with the page 2	Dir	10e. Street and Number			10f. Zip Code			g. Citizen of What Co	ountry r
	eath	eral	118 Stevens Rd.	12. Was Decedent Ever	in U.S. 13.	21060 Was Decedent of H If Yes, specify Cub:	lispanic Origin? (S		SA 14. Race - Ame	
(0	ifter d	by Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No				o Rican, etc.)	Black, Whit	e, etc.
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28s-f show other treumatic event, the Marical Experimentatic event, the Marical Experimentatic event.		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2½ No	Specify:		Specify: W	Mite
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d 2	filed withi Hygiene. other than ent, tre M	ပိ	12 17. Father's Name (First, Middle, Last)		Homen	laker	18. Mother's Nan	ne (First, Middle, M	Own Home faiden Sumame)	:
Maryland	Mental I	To Be	Elmer Schmale				Evelyn H	lopper		
ary	2 should and Men is marka eumatic	-	19a. Informant's Name/Relationship (	Гуре, Print)	19b. Maili	ng Address (Street			City or Town, State,	Zip Code)
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Baltimore,	or oth		20a. Method of Disposition 1 ☐ Burial 2▼ Cremation 3 ☐		Ob. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ce)	Date 2	20c. Location - City or	Town, State
Ĕ	Pa ant ury		*4 □ Donation 5 □ Other (Specifi		letro Cre	The second of th		/2006 C	atonsville	, MD
3alt	permit. Pa Departmer Importent any injury once.		21. Signature of Funeral Service Licer			2. Name and Addre		neral Ho	me at MMP,	INC.
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			shock, or heart failure. List only	one cause on each line.	GBATH. DO HOT BIT	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ig, such as cardiac	or rospilatory and	51,	Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a Ju trac		Hemo	rhage			
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G, (2)	The law requires that the death certifica tte has baen signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant conditions of	ontributing to death but no	ot resulting in the t	underlying cause giv	ven in Part I.		acco use contribute to	~
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on	ding Ih. After funer	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Injury		rk? ]Yes 2∐No		. ,	
Division	Attending r death. Sector: After y the fune	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injury -	At home, farm, si	treet, factory, office	-	28f. Location (Str City or Town	reet and Number or R	ural Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		nysician: To the best of m niner: On the basis of exa and manner stated.	amination and/or in					
200	Fo the within Fo the comple	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed (Mont	
	- > F 0		X pl Ci			PIT	749		3/30/2	006
	10		30. Nam and address of person who	completed cause of death	(Item 23a) (Type	, Print)	. 1		3/30/2 e, MD 2	in the second
_	Y		JOHN CARIOI		GIRECUE	54. 5	12D 4	Sultimor	e, MD Z	1202
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ORIGINAL

			1 - For State Registrar	State of N	Maryland / I		nent of I		ind Me	ental Hy	/giene	06	10428
	Dhysisi		1. Decedent's Name (First, Middle,	Last)					2	2. Date of De	eath		3. Time of Death
	Physici /Media		WILLIAM .	JAMES CARRO	DLL. SR.					Month April	Day 200	Year 16	10:35p M
	Examir	ıer	4a. Facility Name (If not institution,	give street and number	er)	4b.	City, Town,	or Location of	f Death	тртт		ity of Death	1
			GREATER BALTIM				OWSON					TIMOF	RE
	Funeral Director			3. Sex 7. A 1 ☑ M 2 ☐ F	Age (In yrs. last bii		Inder 1 Year oths Days	If Under 2 Hours	Min.	Date of Bi	rth ay, Year)	9. Birth	nplace (State or Foreign untry)
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	yland how		10a. State 10b. County		10c. City, Tow	n or Locatio	)						10d. Inside City Limits
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TLLIA	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	d 1 X Yes 2 ☐ If Yes, Give Year or Dates	]No	101	es 2∭X No	Specify:			Spec	ity: Wh	ite
770	be filed within 72 hours after death with the Marylar ital Hygiene. Indoperthan "natural", or Items 23a or 28e-f show event, the Medical Examinat must be notified at	ted	15. Decedent's	Education		Decedent's	Usual Occup	pation		_	16b. Kind of	Business/I	ndustry
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٠	be fill tal H d otf	Be	17. Father's Name (First, Middle, La								, Maiden Suma	me)	
$20 \mathcal{L}_{\mathcal{L}}$ Maryland 21	should ind Men in marke umatic	ို	Elmer A. Car		T					Jones			
Ma	nd 2 s lth an 27 is treu		Mary J. Carroll	(Wife)							er, City or Town		
₫. ē.	f Healthen		20a. Method of Disposition	(wire)	20b. Place of	Disposition	(Name of		LIMON		Marylan 20c. Location		
A E	Page: lent o nt: if ry or		1 ☐ Burial 2 【A Cremation 3 `4 ☐ Dopation 5 ☐ Other (Spe		8 1 -		or other place	tory 4	4/5/2	006			Maryland
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0	Depa Impo any Ir		Martin D.	awson		Mit	chell-	Wiedef	feld	Funera	al Home	, Inc	
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o I	at the de by the a tached f	Physician/Me	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of death	5 Othe	(specify)				M	onth	Day Year
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certific death. sctor: After this certificate has been signed by the attending py the funeral director, page 2 should be detached for use as	H-	Part II. Other significant conditions	contributing to death t	but not resulting in	the underly	ng cause give	en in Part I.		23e. Did to	obacco use con	tribute to t	he cause of death?
sp	luires that r signed t	d by		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	3			101	1		bably 4 Unknown
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Re	The lavate has	Completed							_	autop perfo	rmeg?	death?	opsy findings available impletion of cause of
ital	sician: The certificate rector, pag	BeC	25. Was case referred to medical examiner?					26. Place of	f Death (C	1 ☐ Yes	7	1 ☐ Yes	2 No
>	Physic this ce	ဦ	1 Yes 2 No	Hospital: 1 Inpati	ent 2 ER/Out	patient 3	DOA Othe				lence 6 Oti	ner (Specif	y)
5	ing P	ë.	27. Manner of Death Natural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. T	jury	28c. Injury Work	at c?	28d	. Describe h	ow injury occu	red	
isic	ttend death stor:	cat	2 Accident investigat 3 Suicide 6 Could not	be as a		М		Yes 2 □No					
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	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical	(Check only 2 Medical Expone)	aminer: On the basis o and manner st	or examination and	Vor investiga	tion, in my op	oinion, death	occurred a	at the time, o	date and place,	and due to	the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier	0			29c. License	number		3	29d. Date signe		Day, Year)
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5	1		30. Name and address of person wh	completed cause of c	death-(frem 23a) (	Type, Print)	, ,	J .	2	,			
	Stat	e.	MANK STNOM 31. Date filed (Month, Day, Year)	32 Aegistr	rar's Signature	COO	ve s	- /	Sa 11	4.00 L	1 10		
	Registra		APR 0 5	2006	death (frem 23a) (7	Soul	1						

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Davis.	Elvis

Physician/ Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

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n/ er	Decedent's Name (First, Middle,Last	Elvis Ray	Davis				2. Date of Dea Month April 3, 20	Day	Year	3. Time of De 6:12	eath
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	5. Social Security Number 6. Se 220 70 1884	- 10	s. last birthday)	If Under Months		If Under 24Hrs. Hours Min.			Co	thplace (State buntry) Marylan	
_	Usual Residence of Decedent  10a. State 10b. County  Maryland Anne A		ity, Town or Loca Gambrill							10d. Inside 0	City Limits
Directo	10e. Street and Number 1344 Defense Hi	ghway Apt 2		10f. Zip C	ode 1054	<b>,</b>		_	of What Cou	ntry?	
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npietea p	15. Decedent's Education (Specify or Elementary/Secondary (0-12) 12th		during most o	ent's Usual Oo f working life.		n (Give kind of w	vork done		of Business/	Industry Finishe	er
Be Cor	17. Father's Name (First, Middle, Last) Ray Da	vis					Marie Mo	Maiden Sui	rname) 1gh		
O_	19a. Informant's Name/Relationship (T Rea Aldridge / Fr 20a. Method of Disposition	iend		Defen	se H	and Number or F lighway tery,		ills,		and 210	54
Examiner	failure. List only one cause on ea Immediate Cause (Final disease or condition resulting in death)  Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	lications that caused the dech line.  Complications of Chiral Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence Due to (or as a conseque	40 ath. Do not enter conic Alcohol e of):	Ol Rit	chie	Facility Go: Highwa Ich as cardiac o	ıy Balt	imore	e. Mary	7 land 2 Approxima Between C De:	1225 te Interva Onset and
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Compl	25. Was case referred to medical			26	Place o	f Death (Check	1 Yes	ormed?	death?	es 2	No
0	overnings?	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	ER/Outpatie	nt 3 DO.	A Of	the many transfer	ng Home 5		e 6 🗸 Othe	er: Scene	
Medical Certification:	3 Suicide 6 Could not determined 4 Homicide	be 28e. Place of Injury - A					28f. Location ( or Town, s	State)			mber, City
Medica	(Critical Crity	r:On the basis of examination and manner stated.	-	ation, in my c		leath occurred a		and place	, and due to th		-)
_	1 \ 1 \	mo			D.C.M				, 2006	= 551 . 561,	′

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)
APR 0 5 2006



DHMH 17 Rev 1/2001 OCME 10/2003

Radoslaw B. Dudczak 06-2123AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene te of Death Reg. No.

1 - For State Registrar	Otato of	Certifica
1. Decedent's I	Name (First, Middle, Last)	

Physician
/Medical
Examiner

Baltazar 4a. Facility Name (If not institution, give street and number)

4b. City, Town, or Location of Death

3. Time of Death 5<sup>Day</sup> 2006 March 26, 11:46 PM

**Funeral** 

Director with the Maryland r 28e-f show Director other then "neturel", or iteme 23a or vent, the Medical Examinar must be Funerai filed within 72 hours after death þ Completed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked oth eny linjury or other traumatic event SDRB. Be

**Physician** /Medical Examiner

attending for use as

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and

.O. Box 68760.

Division of Vital Records, P.

Baltimore, Maryland 21215-0036

Marlboro Pike near Donnell Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1√2 M 2□ F 107-90-8834 26 Usual Residence of Decedent

Capitol Heights If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

4c. County of Death Prince George's

8. Date of Birth (Month, Day, Ye 5/13/

2. Date of Death

 Birthplace (State or Foreign Country) Polland

10a. State 10b. County Md Prince George's

Forestville

10c. City, Town or Location

10d. Inside City Limits 1 ☐ Yes 2 XNo

10e. Street and Number 6301 Hil Mar Drive Apt.

0

20747

10g. Citizen of What Country? USA

11. Marital Status

Radoslaw

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:

Dudczak

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔂 No Specify.

 Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12

College (1-4or 5+)

Independent Contractor

Renovation

17. Father's Name (First, Middle, Last) Henryk Dudczak

19a. Informant's Name/Relationship (Type, Print)

Teresa

Puchala 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Teresa Dudczak / Mother

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, crematory or other place)

42-200 Czestochowa UL.Okulickiego 2AA/32 Date 20c. Location - City or Town, State

1 ☐ Burial 2 In Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify)

Bayview Crematory 3-31-06

Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA

21. Signature of Funeral Service Licenses Entos 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

1201 Dundalk Ave. Baltimore, Md. 21222 Approximate Interval Between

18. Mother's Name (First, Middle, Maiden Surname)

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

HU	ي	hol	<u>_</u>	iNi	45	105	ح
D	ue to	or as a	consec	nence	of):		

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

Completed by Physician/Medical

Be

Certification: To

Medicai

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

25. Was case referred to medicat examiner?

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year

Onset and Death

9 Unknown

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☑ ▼es 2 ☐ No

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at Scene

1 tes 2 □ No 27. Manner of Death 1 Natural

4 Homicide

5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 3/26/06

28b. Time of Injury 23:36 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 🛣 No

28d. Describe how injury occurred

driver auto auto collision

29a. Certifier

may 00 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

road

281. Location (Street and Number or Rural Route Number, NB ity or Town, State) Pike Copito Head

29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) March 27, 2006

30. Name and address of person who completed cause leath (Item 23a) (Type, Print)

ARON TATRICIA 01 32. Registrar's Signature

31. Date filed (Month, Day, Year) APR 0 5 2006 Kulli Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

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i Director: And in by the f

		for State Registrar	State of N	Marylan	-			ealth a Death	and M	lental Hyg	iene	6	10431
Physici	an	Decedent's Name (First, Middle								2. Date of Deat Month		Year	3. Time of Death
/Media	cal	Frances E.	Dembeck							Month APRII	<del></del>	2006	8:50F M
Examin	ier	4a. Facility Name (If not institution Saint Josep	h Medical	Cent					)WSO	n	4c. County	of Death Balt	imore
Funeral Director		5. Social Security Number 219-22-222	6. Sex 1 ☐ M 2 ☐ F	Age (In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, June 19	Year) 1925	Cour	place (State or Foreign ntry) YLand
and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
Maryi -f eho	tor	Maryland Balt	ima <i>n o</i>			rkvil	l o						1 ☐ Yes 2 No
th the or 28a	Director	10e. Street and Number					Code			11	Og. Citizen of	What Cou	ntry?
23a c		8800 Walther	Blud., Apt	. 3216				21234			u.	S.A.	
ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene. It of Health and Mental Hygiene. or items 23a or 28a-f ehow or other treumatic event, the Madical Examinar must be notified at	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Mari	Was Give	s?	1	Was Dece If Yes, spe 1 ☐ Yes	11.	spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	Bia	ck, White,	can Indian, etc. Ute
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id 2 sh Ith and 27 is m treum		19a. Informant's Name/Relations Mr. Ben Slowik	hip (Type, Print) (nephew	)						i Route Number O <b>たk。 PA</b>	City or Town, 17403	State, Zip	Code)
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permit. Pages 1 and 2 Depertment of Health a Important: if item 27 is eny injury or other tree		21. Signature of Funeral Service	Licensee Rin	no Ro						himunek Limore,	Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro		nes
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		í	For State Registrar	State of I	Maryland		rtment of H tificate of		and M		iene 200 eg. No.	6	0432	
l <sub>a</sub>		61	1. Decedent's Name (First, Middle, Las					2. Date of Dear	th Day	Year	3. Time of Death			
	Physician Paul Jerald Dallman								MANCH	28,20	-	1020 M		
	Examin		4a. Facility Name (If not institution, give	street and numb		4b. City, Town, or Location of Death				4c. Count	ty of Death	40		
100			125 Fring.	Stree	1		La	urel	_		Sin	ce 1	6 eages	
	Funeral		5. Social Security Number 6. Si	9X 7.	Age (In yrs. Ia: 67		If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day)	Year)	9. Birthp	place (State or Foreign	
120	Director		214-30-3219	A. F. L.	07	Yrs.				July 7,	1938	Wash	ington, DC	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	10d. Inside City Limits	
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36	flied within 72 hours after death with the Maryland Hydione. Ither then "natural", or teme 23e or 28e-f show ent, the Madical Evant, or must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	Armed Force 1 ☐ Yes 25 If Yes, Give Year or Date	Çĭ∧o	1	☐ Yes ŽŽNo		i, Pueno	rican, etc.)	Speci	ack, White, ' <sup>ry:</sup> Wh	etc. ite	
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<u>×</u>	Ment Ment arked	၉	Paul Frederick Da	allman				Hel	en F	Roloff				
Maryland	2 sh and le m		19a. Informant's Name/Relationship (1				g Address (Street						Code)	
o o	l and fealth im 27	,	Deborah Ann Kent/S	sister	20h Pla		Charles S	street	-	_		21701	C4-1-	
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Be	The law	E								autops	med?	prior to co	mpletion of cause of	
ta	iclan: Th certificete rector, pag	0	25. Was case referred to medical					26 Place	of Deat	1 ☐ Yes	2 € No	1 🗆 Yes	219140	
		ToB	examiner? 1 ☑ Yes 2 ☐ No	Hospital: 1 ☐ Inp	atient 2 🗆 E	R/Outpatien	t 3 DOA Ot	hac		ome 5 Reside		ther (Specif	(v)	
0	g Physical dispersal di	<u>-</u>	27. Manner of Death	28a. Date of		28b. Time of Injury	28c. Inju	rv at	-	28d. Describe h		-	,,	
<u>ō</u>	Attending in death. ector: After by the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		Day / Gar/	mjury		Yes 2 □	No					
Division of	or Attendated after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of	Injury - At hon, etc. (Specify)		eet, factory, office 28f. Location (Stre City or Town,				reet and Number or Rural Route Number,			
0	itel o			1										
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Examone)	ysician: To the be niner: On the bas and manne	is of examination	ledge, death on and/or inv	occurred at the ti restigation, in my	me, date an opinion, dea	id place, ith occur	and due to the c red at the time, d	ause(s) and n late and place	nanner as s , and due to	tated. o the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licen	se number		2	9d. Date sign	ed (Month,	Day, Year)	
			Salvado	12/3	to 2	0	H	2557	92	7	MANO	2 31	2006	
	12		30. Name and address of person who	co of leted cause	of death (Item	23а) (Туре,	Print)					1	2006 [ANd	
	100		SALVADOR Sylva	Try 30	001 H	ospi 7	tal D.	ine	_C	Leverl	, 1	1115	land	
33	Sta		31. Date filed (Month, Day, Year)	32. R	istrar's Signatu	Jre /	certi			V	17			
14 A	Regist	rar	APR 0 5	2006	ASIAS I	N. 12	7							

			Please	State of Maryland /				•
			State Registrar		Certificate of	Death	Reg. N	000 10430
	Physici /Medic		1. Decedent's Name (First, Middle, Las  MARYAW	N DARN			04 0	
	Examin	er	4a. Facility Name (If not institution, give	street and number)  = MARYLAND M	EDICAL CENTE	FR RALTI	MORE	c. County of Death
	Funeral Director		5. Social Security Number 6. Se 136 30 264 1			If Under 24 Hrs. 8	B. Date of Birth (Month, Day, Year (DA / 15 / 19	9. Birthplace (State or Foreign Country) New Jersey
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits
	e Man	Director	Maryland Anne A	runde1	Odenton			1 ☐ Yes 2 🔀 No
	with th		10e. Street and Number	#201	10f. Zip Code	112		citizen of What Country?
	ne 23	Funeral	2602 Clarion Cou	12. Was Decedent Ever in U.S.	13. Was Decedent of H	113 Hispanic Origin? (Speci	itv Yes or No-	14. Race - American Indian,
Maryland 21215-0036	s 1 end 2 should be filed within 72 hours after deeth with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, its Medical Exercitations traumatic event, its Medical Exercitations.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	If Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, Puerto Ri	ican, etc.)	Black, White, etc.  Specify: White
20	72 hc	Completed	15. Decedent's Ed (Specify only highest grad		Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of working	16b.	Kind of Business/Industry
121	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Homemake			Own Home
<u>م</u>	e filed within al Hygiene. I other then vent, I've Me	BeC	17. Father's Name (First, Middle, Last)	1/1		18. Mother's Name (	First, Middle, Maide	nn Sumame)
ylar	2 should be and Mental Is marked o	To	Lawrence H			Eleanor		yer
Mar	id 2 shouth and 27 is m		19a. Informant's Name/Relationship (7) William Tone Darne		9b. Mailing Address <i>(Street</i> 1602 Clarion			or Town, State, Zip Code) , Maryland 21113
	s 1 end f Health item 27 other to		20a. Method of Disposition	20b. Place	of Disposition (Name of tery, crematory or other pla			Location - City or Town, State
Ë	nit. Peges partment or cortant: If injury or		1 Burial 2 Cremation 3 — 4 Donation 5 Other (Specify	removal from State	Arundel Crem	l l	2006 Od	enton, Maryland
Baltimore,	permit. Peges 1 en Department of Heal Important: If item 2 eny injury or other once.		21. Signifure of Funeral Service Licentum R	homas	1411 Anna	polis Road	Odenton	matory, P.A. , Maryland 21113
Set)			23a. Parti, Enter the disease, or composition, or heart failure. List only of				respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. PUL MOWARY  Due to (or as a consequence	DE COMPEN	SATION		
	Examiner		Securentially list gooditions	Atrial 1	Eibrillati	01		
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	ce of):			
<u>_</u>	e be executed sicien and e burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	ee of):			
160	ysicier ysicier	70	· ·	d				
x 68	ertifica ling ph	Med	IF FEMALE:	00-14				
P.O. Box	that the death certificate ed by the ettending phys detached for use as the	Physician/Medic	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		у		23d. Date of delivery Month Day Year
	taw requires that the death certificate as been signed by the ettending phys. 2 should be detached for use as the	by	Part II. Other significent conditions or	ontributing to death but not resulting	g in the underlying cause gn	ven in Part I.		use contribute to the cause of death?
of Vital Records,	The ate h page	Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 □ No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	0#	26. Place of Death (		
	\$	tion: To	1 Yes 2 No  27 Manner of Death  28 No  29 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	outpatient 3 DOA  28c. Injury Wo	4   Nursing Home	e 5 Residence	6 □Other (Specify) ury occurred
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		farm, street, factory, office	28	3f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	he Hospitel n 24 hours a he Funersi C	edical C	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowled iner: On the basis of examination and manner stated.	Ige, death occurred at the ti and/or investigation, in my o	me, date and place, an opinion, death occurred	nd due to the cause( d at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	ш	29c. Licens	se number	29d. D	ate signed (Month, Day, Year)
)	1.		V Siana Car	igacianu, "		+4	5	1/3/006
	Ψ		30. Name and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen and address of person who can be also seen as a seen and address of person who can be also seen as a seen and address of person who can be also seen as a seen as a seen as a seen and address of the seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as a seen as	STREET, Dea	a) (Type, Print) pt of Suri	GERY BA	LTIMORE	MD
	Sta Registi		31. Date filed (Month, Day, Year)  APR 0 5 20	32. Begistrar's Signature	bosile	,		

State of Maryland / Department of Health and Mental Hygiene 10434 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 30, 2006 **Physician** 10:42 PM Frank Joseph DeMario /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y May 21, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 1 M M 2 □ F Yrs Maryland 89 Director 218-10-8607 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Heelih and Mental Hyglene. Important: If Item 27 is marked other then "naturel", or Iteme 23s or 28s-f ehow by Injury or other treumatic event, Its Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Directo Baltimore Baltimore Marvland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? USA 21222 25 Admiral Blvd. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 TYes 2 □ No If Yes, Give WWII Year or Dates: 1 Never Married 2 Married Specify: White Maryland 21215-0036 1 ☐ Yes 2 🛣 No Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BP Industries 6 Oil Burner Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Orsola DiSilverio Antonio D'Amario 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 25 Admiral Blvd.; Baltimore, Maryland 21222 Stephanie Halcott Daughter Baltímore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Catonsville, Maryland Metro Crematory 4 Donation 5 Other (Specify) rematory 4/5/2006 Catonsville, Marylan

22. Name and Address of Facility Sterling Ashton Schwab Litzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee Approximate Interval Between Ons and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer lailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) edermors a Pnysician 2 scheme ens /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sicien and burial-transit Due to (or as a consequence of): Be Completed by Physician/Medical igned by the ettending physical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy IEPHROSCLEROSIS performed? 1 Yes 2/2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To To the Hospitel or Attending Phwithin 24 hours after death.
To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of ¢ertifier 29c. License number 29d, Date signed (Month, Dav. Year) MA 106 who completed cause of death (Item 23a) (Type, Print) 6 31. Date filed (Month A) 32. Registrar's Signature State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	te of Marylan			of Health		-	giene Reg. No.	16 I	0435
			Decedent's Name (First, Middle, Last)						. Date of De	ath		3. Time of Death
	Physicia		Earl Stanley Drumwright					P	Month	O \	2006	0852AM
	/Medic Examin		4a. Facility Name (If not institution, give street as	nd number)		4b. City, 7	Town, or Location		-	1	nty of Death	
450	LAGITITI		ST. AGNES	HOSP	TAL	By	altim	Opt	=			
6	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year If Under Days Hours	Min.	B. Date of Bir (Month, Da	th v Year	9. Birthpl Coun	lace (State or Foreign
. 500	Director		219-26-8163	□ F 67	Yrs.	WIOITIIS	Days		7-27-19	38	Mary1	and
	p .		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	cation					11	0d. Inside City Limits
	anyla •hov	7	Too. County	100. 011							''	1 X Yes 2 □ No
	8a-f	Director	MD NA		Baltin		0-1-			10= 0%	of What Coun	
	with t	급	10e. Street and Number			10f. Zip						try r
	s 23	eral	610 Wildwood Pkwy  11. Marital Status 12. Was	s Decedent Ever in U	S 13 V	Vac Daced	21229 ent of Hispanic Or	rigin? (Speci	fy Yes or No		JSA Race - America	an Indian
	after death with the Marylan or items 23a or 28a-1 ehow pliner sout be notified at	Funeral	Arm	ned Forces?	10. 1	Yes, spec	rfy Cuban, Mexica	n, Puerto Ri	can, etc.)	8	Black, White,	etc.
39	irs af	by F		es, Give ar or Dates:	1	☐ Yes 2	No Specify	*		Spe	city: Black	
21215-0036	72 hours "natural", elical Exi	led	15. Decedent's Education		16a. Deced	lent's Usua	I Occupation				Business/Inc	
215	nin 72 nin 'ni	ple	(Specify only highest grade comp.  Elementary/Secondary (0-12) Coll	leted) lege (1-4or 5+)	(Give life. L	kind of wor DO NOT us	k done during mo: e retired)	st of working	7			
21,	e filed within it Hygiene. other than	Completed	12			Fact	ory Worker			Fa	actory	
P	be filed within 72 hours after death with the Maryland ital Hygiene. of other than "natural", or items 23a or 28a-f ehow event, the Medical Examinant and be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Moth	er's Name (	First, Middle	Maiden Sum	name)	
<u>la</u>	uid b Venta urked	2	Leroy Johnson					Lotti	le Drumw	right		
Maryland	2 should be it and Mental I ie marked of reumatic eve		19a. Informant's Name/Relationship (Type, Prin	nt)		-	(Street and Numb				wn, State, Zip	Code)
	and 2 Balth n 27 i		Doretha Lee/ Sister				ood Pkwy B	altimor	re, MD 2	1229		
Saltimore,	- 1 6 5	1.0	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remova	1 -	Place of Dispo- emetery, cren	sition (Nam natory or ot	ne of ther place)	Dai	te	20c. Locatio	on - City or To	wn, State
Ĕ	Pages nent of I ant: If its ury or o		4 □ Donation 5 □ Other (Specify)		. Zion C	Cemeter	y	04-08-0	)6	Lansdov	wne, MD	
<u>a</u>	permit. Departr Importa eny inje		21. Signature of Funeral Service Licensee	$\sim$			d Address of Facil	1				
	90 F 9 9		Surerla yone		Wy	lie Fu	neral Home	638 N.	Gilmor	St. Ba	ltimore,	MD 21217
CKR (	Physician // Medical Examiner prize pe executed physician and the prize transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	the on each line.  HWCFOSCL  Due to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a conseque to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or as a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a consequent to (or a conseque	uence of):	- Cc	pronar	y Vas	scula	- Disc	ease (	Interval Between Onset and Death
1t, F	it the death certific by the attending parched for use as	Physician/Medic	in the past 12 months?	es, outcome of pregna ]Live birth 2 □ Feta ]Pregnant at time of d ]Unknown	Ideath 3□	Ectopic pro			1		Date of delive Month	Day Year
C. VS	res tha igned be de	by P	Part II. Other significant conditions contribution			nderlying ca	ause given in Part	1,				e cause of death?
	w requir been si should l	ted	Ischemic C	ardiomy	opati	<u> </u>			10	Yes 2□No	3 Prob	ably 4 Unknown
$\mathcal{S}$	law ras be	Completed	Diabetes			<i>/</i>			24a. Was auto		b. Were autop	psy findings available inpletion of cause of
2 =		P P	Hypercholest	erolemi	,a				perfo 1 ☐ Yes	rmed?	death?	
ita	icien: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?					e of Death	Check only	one)		
_	hysic his ce	2	1 ☐ Yes 🔊 No Hospital	1 L Inpatient	ER/Outpatien			ursing Home	e 5 ☐ Resi	dence 6 □	Other (Specify	/)
3	ng P	 	27. Manner of Death 28a.  1 Natural 5 □ Pending	Date of Injury (Month, Day Year)	28b. Time of Injury		8c. Injury at Work?		d. Describe	how injury oc	curred	
Sio	tendi leath. lor: A	Certification;	2 Accident investigation 3 Suicide 6 Could not be			М	1 Yes 2					
	or At fler d Direct in by	£	4 Homicide determined 28e.	. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory	, office	28	City or To	street and Nu wn, State)	imber or Rura	I Route Number,
~ 70	pitel urs a eral [		Continue 1 Continue Division	T- 4- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1- 1-				-1-1				
	Hos 24 ho Fun	edical	29a. Certifier 1 Certifying Physician: (Check only 2 Medical Examiner: Or	the basis of examina d manner stated.	tion and/or in	vestigation,	at the time, date a in my opinion, de	nd place, an ath occurred	d at the time,	date and place	manner as st ce, and due to	ated. the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. I	Med	29b. Signature and title of certifier / 1	S. Mariner States.		290	: License number			29d. Date sig	ned (Month, i	Day, Year)
	⊬₃≓ŏ		Mandete	+ MI	7		Dan	5.33	12	Apr	-il 1.	2006
	0		30. Name and address of person who complete	deause of death (Iter	n 23a) (Tune	Print)						
_	0		Michelle Henggeler	, 900 cat	on A	renu	e, Be	altin	nore i	MD	212	29
	Sta Registi		31. Date filed (Month, Day, Year)	32. Figistrar's Signa	H. A	and I						

			1 - For State Registrar	State of Maryla		artment of F		-	giene Reg. No.	006	0436
ı	Physici	an	Decedent's Name (First, Middle, La  TAME C		7.0			2. Date of De Month FEB.		2006°	3. Time of Death
	/Media	al	JAMES  4a. Facility Name (If not institution, gi	DANIE	Г2	4h City Town o	r Location of Death			2006 County of Deat	15:10 p <sup>M</sup>
	Examir	er	PRINCE GEORGE			HYATTS				11 1 1 1 1 1 1	EORGES
	Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs	s. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Bir	th	Q Rint	hplace (State or Foreign untry)
	Director		578-68-4885 Usual Residence of Decedent	1X M 2□ F 5	5 Yrs.	Morkins Days	Tiodis Will.	(Month, Da 1 – 2 4 –	195	1 WAS	HINGTON, DO
	yland iow		10a. State 10b. County	10c. C	City, Town or Lo	ocation					10d. Inside City Limits
	e Mar	ctor	DC		WASHI	NGTON					1 DXYes 2 □ No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	untry?
	eath v	erai	706 BRANDYWI	NE ST., SE			0032	acifu Voc or No		S.A.	door ladia.
0	after d	Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		Was Decedent of H		Rican, etc.)		Black, White	e, etc.
003	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Madical Examination untilled at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:			Specify: B	LACK
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<u>ya</u>		T <sub>o</sub>	JAMES	WATERS			HELEN		ARII		DANIELS
altimore, Maryland 21215-0036	12 s		19a. Informant's Name/Relationship  DONNA P. HINTO			ng Address (Street BRANDYW					
ē,	s 1 and f Healt item 2 othar t		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place		Date // 2		ation - City or	
Ë	Pages nent of int: If it		1 <sup>th</sup> Burial 2 □ Cremation 3 [ '4 □ Donation 5 □ Other (Speci					7/06	BALT	TIMORE	, MARYLAND
Balti	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Lice		22	2. Name and Addre	ROWALD	TAYLOR	,II	FUNER	AL CHAPEL
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	Phy <del>sicia</del> n /Medical	1	disease or condition resulting in death)	aSEPTICE							
	Examiner		Sequentially list conditions	b							
4	be sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):						
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a conse	equence of);						
8760	cate be e	dicai E		d							
9	the death certificate be executed y the attending physician and Iched for use as the buriat-transit	Medi	IF FEMALE:								
Box	eath certific attending p i for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second o	tal death 3	Ectopic pregnancy Other (specify)			23	3d. Date of deli Month	very Day Year
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ord	w require been si should b	ted	RESPIRATORY					1 🗆 1	∕es 2□	]No 3 ☐ Pro	obably 4 X Unknown
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n of	or Attanding Physician: ufler death. Director: After this certific in by the funeral director,	J: Lo	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		/ at	28d. Describe h			,,
Division	death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	000 1 12 46			
2	after dated Direct	Certification;	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, str	eet, ractory, onice		City or Tow	ireet and m, State)	Number or Hu	ral Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled		29a. Certifier 1 Certifying P	hysician: To the best of my kr	nowledge, deat	h occurred at the tin	ne, date and place,	and due to the	cause(s) a	and manner as	stated.
	To the H within 24 To the F complete	Medicai	0.16)	miner: On the basis of examir and manner stated.	nation and/or in						
)	To To con	2	29b. Signature and title of certifier	2/8/1		29c. License				signed (Month	
	di		30. Name and address of person who	completed cause of death /lite	am 23a) (Tupe		26024		MAK	CH 24,	2006
			LESTER MILES	S, M.D 64	90 LA	NDOVER R	COAD, LA	NDOVER	, MI	2078	2
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5	32. Segistrar's Sign	nature	oute					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ( )

			1 - For State Registrar	State	of Mary		partment of F		nd Men		ene() []	6		37
			Decedent's Name (First, Middle, Last	st)						Date of Death		Vans	3. Time of I	Death
	Physici: /Medic		GRACE DENNIS						Mar	ch 28	, <sup>Day</sup> 2006	Year	10:30	АМ
	Examin		4a. Facility Name (If not institution, give		mber)		4b. City, Town, o		Death		4c. County of			
· y			1311 Early Oaks				Fairmor		4 Han I a s		Prince			
	Funeral		5. Social Security Number 6. S 579–78–9017	lex □M 21⊠F	7. Age (II	n yrs. last birthda Yrs.	y) If Under 1 Year Months Days	Hours 1	Min. (	Date of Birth Month, Day,	Year)	9. Birthp	place (State or htry) 5 It /NGTO	Foreign
	Director		Usual Residence of Decedent		30				Jar	nuary 9	, 1930	VVA	71(7/06/0	. 00
	yland		10a. State 10b. County		10	Oc. City, Town or	Location					1	0d. Inside Cit	
	e Mar	ctor	DC		V	Washingt	on						M∑Yes	2 🗌 No
	or 28	Director	10e. Street and Number				10f. Zip Code				g. Citizen of W			
	ath w	rai	745 12th St SE	140 141	V 5		20003		i=0 /C===it-		nited S		S can Indian,	
	ter de	Funeral	11. Marital Status  ↑★Never Married 2 Married	12. Was Dec	orces?	erin U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	an, Mexican,	Puerto Rica	n, etc.)		k, White,		
ဦ	urs aff	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1 ☐ Yes 2़्िNo	Specify:			Specify:	Bla	ck	
2-003d	2 hou		15. Decedent's Ed	ducation		16a. De	cedent's Usual Occup	ation	of working	1	6b. Kind of Bus	siness/Inc	dustry	
<u>'</u>	thin 7	Completed	(Specify only highest gra		1-4or 5+)	life	ve kind of work done  . DO NOT use retired	d)	or working					
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yland	be fill H of other	Be	17. Father's Name (First, Middle, Last) George Dennis	)				Doroi		rst, middle, m 1athis	aiden Sumame	3)		
<u> </u>	d Mer nark	은	19a. Informant's Name/Relationship (	Tuna Print)		19h Ma	iling Address (Street				City or Town	State Zir	Code	
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Đ,	Heal Heal tem 2		20a. Method of Disposition	0.000	:	20b. Place of Dis	position (Name of rematory or other place	20)	Date	2	Oc. Location - (	City or To	own, State	
<u> </u>	Pages ent of nt: if i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		State		1s Cemeter		-3-200	06 (	Clinton	NC		
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Ď	P E E E		valora,	MA	16		2617 Penn	Ave SI	E Wash	ningtor	DC 200	020		
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6/00,	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C		onsequence of):								
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Hecords,	ilcian: The law requ certilicate has been rector, page 2 shoule	Complet								24a. Was an autopsy perform	ed? d	Vere auto rior to co leath? Yes	opsy findings a impletion of ca	ivailable iuse of
אונשו א	ysician: is certific director,	Be	25. Was case referred to medical examiner?						of Death (Ci	heck only one	)		E	-
Ä	this al di	ဥ	1 ☐ Yes 2 ☑ No		Inpatient	2 ER/Outpat	ient 3 DOA			5 Resider	· · · · · · · · · · · · · · · · · · ·		home	ers
	ding P	lon	27. Manner of Death  1		of Injury oth, Day Y	(ear) 28b. Time Injur	y Wo	ryat rk? ∣Yes 2.∐N		Describe nov	w injury occurre	∌d		
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4	1/3		30. Name and address of person who			th (Item 23a) (Typ	pe, Print)		. 1/		, ,	- 1	WASH	FDY
			DEVIKA		V) (5	) CS E	KCKIT	101	/ /V.	CAPI	tol c	)r '	2000	2_
1/2 1/2	Sta Registi		31. Date filed (Month, Day, Year)		Hegistrar's	Signature	enter							
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			For State Registrar	State of M	aryland / Depa	artment of Heartificate of De		ental Hygie Reg.	4000	10438
	Physici		1. Decedent's Name (First, Middle,	Last)			2	2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	ESTELLE 4a. Facility Name (If not institution,	FANCHON give street and number)	DESMC	ND 4b. City, Town, or Lo			2006 4c. County of Death	5 A M
			STELL ROSS			BALTIMO			N/A	
	Funeral Director		216 42 6556	6. Sex 7. Ag 1 □ M 3√√F	ge (In yrs. last birthday) 61 Yrs.		Hours Min.	B. Date of Birth (Month, Day, Ye MAY 4	oar) Coui	place (State or Foreign ntry) YLAND
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation			1	0d. Inside City Limits
	the Marylar 28a-f show	ō	MD. N/A		BALTI	MORE			İ	1√ Yes 2 □ No
	r 28a	rec	10e. Street and Number		DALL	10f. Zip Code		10g.	Citizen of What Cour	ntry?
	h with	ai D	124 S. POTO	MAC ST		21224	4		USA	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23e or 28e-f show important: If item 27 Is marked other than "natural", or Items 25e or 28e-f show appringly or other traumatic event, the Healtest Exertifier mainted at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? ad 1 Tyes 247 If Yes, Give X Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, I 1 ☐ Yes	anic Origin? (Speci Mexican, Puerto Ri Specify:	ity Yes or No- ican, etc.)	14. Race - Americ Black, White, Specify: BL.	etc.
215-0036	n "natur	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	(Give	dent's Usual Occupatio kind of work done duri DO NOT use retired)	on ing most of working	7 168	b. Kind of Business/In	dustry
212	d within giene.	E	GED GED	College (1-4or		CAL ASSIS	STANT		HOSPITA	L
	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, L			18	8. Mother's Name (	First, Middle, Mai	den Sumame)	
yla	should the marked marked umartic of	ဥ	CHARLES TAY				IRENE			
Maryland	12 sh h and 7 la m rraum		19a. Informant's Name/Relationsh IRENE F. DESMO		7	ng Address <i>(Street and</i> 9 Alsa E	d Number or Rural I BALTO , MD			Code)
	1 and Healt em 2 ther t		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	Da	0.4	L 4 Location - City or To	own, State
nor	ages nt of t: If it		1 Buria 2X Cremation		cemetery, cre	matory`or other place) OUNT CREM	"APR <sub>→</sub> 7	2006		
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0	that	y P	Part II. Other significant condition	ns contributing to death t	out not resulting in the u	inderlying cause given i	in Part I.	23e. Did tobac	co use contribute to t	ne cause of death?
rds	w require: been sig should b	ed b						1 🗌 Yes	2 □ No 3 □ Prob	pably 4 Unknown
Records,	law requas been 2 should	Completed by						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
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Vital	Attending Physician: The lar r death. ector: After this certificate has by the funeral director, page 2	Be (	25. Was case referred to medical examiner2				6. Place of Death (	(Check only one)		
of \	hysi this c	ြ	1 49s 2 No.	Hospital:			4   Nursing Home		e 6 her (Specif	y) SHELTER
on c	ding F h. After funera	ion	27. Manner Death 1 Unitural 5 Pending		ay Year) 28b. Time o	Work?	t 28 s 2 □No	ld. Describe how i	injury occurred	
Division	Nttendii death. ctor: A y the fu	licat	2 Accident investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation investigation inves		iury - At home farm st			If. Location (Stree	t and Number or Rura	al Route Number.
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	To the To the Comp	Me	29b. Signature and title of certifler	11	Max	29c. License n	number	29d.	Date signed (Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Dav Physician Ilse M. DeLong 30, 2006 March 7:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 🗓 F Yrs 139-32-3844 Director 83 July 8, 1922 Germany Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5814 Beech Avenue 20817 Iteme 23a United States Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, elc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced "neturel", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Peges 1 and 2 should be finent of Health and Mental Health and Mental Health and marked of Wilhelm Schulte Martha Gruendel ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gwynne E. DeLong/Daughter 2845 Komichan Lane, N.W., Seabeck, Washington 98380 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State April 6. 0= 0 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny injury or once. Montgomery Crematorium, Inci 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signalure of Funeral Service Licer See Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or treat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute Myocardial Infarction Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 🖾 No Day Month Year 4□Pregnant at time of death 5 Other (specify) P.O. P. detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Division of Vital Records. ģ page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 No Physicien: After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No To the Hospitel or Attending Pt within 24 hours effer death.
To the Funeral Director; After th completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Eseno 1 Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 5154 WS N IN AVE CHUY CHAR MERCHAND 20815 13000

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Prigistrar's Signature

			101	artment of Health and Mental Hygiene
٦	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year  A 1 - Day A 2 - Day A 3 - Time of Death
	/Medic Examin	al	PAUL L, EVERETT  4a. Facility Name (If not institution, give street and number)	MARCH 31,2006 6:47 P M  4b. City, Town, or Location of Death  4c. County of Death
		ŭ.	1 TREMAINE CT.	WOODLAWN BALTIMORE
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  512-14-0038 1	If Under 1 Year   If Under 24 Hrs.   8, Date of Birth   9, Birthplace (State or Foreign   Months   Days   Hours   Min.   2 Man   2 Man   2 Man   2 Man   2 Man   3 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 Man   4 M
	4		Usual Residence of Decedent	
	ith the Marylar or 28a-f show	o	MD. BALTIMORE WOODLAWN	4 DVan 0 DNa
	r 28a-	irect	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	ath with	raiD	1 TREMAINE CT.	21244 USA
	filed within 72 hours after death with the Maryland Hygiene. thar than "natural", or items 23a or 28a-f show int. The Modical Examitment wat the multifled at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
21215-0036	ours a	by	3 ☐ Widowed 4 🛣 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify: Specify: BLACK
15-0	n 72 h	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)
212	filed withi Hygiene. thar than int. If a M	ошо	Elementary/Secondary (0-12) College (1-4or 5+) -4 -	SUPERVISOR SOCIAL SECURITY
	outd be file Mental Hy, arked oths atic evant.	To Be C	17. Father's Name (First, Middle, Last)  GOLDIE N. EVERETT	18. Mother's Name (First, Middle, Maiden Surname)  IRENE REAVES
Maryland	and and is m			ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 OAKFORD AVE. BALTIMORE, MARYLAND 21215
Baltimore,	of Health of Health if itam 27 or other tra		20a. Method of Disposition  1X Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition cometery, creations are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely and completely are completely are completely and completely are completely and completely are completely are completely and completely are completely are completely and completely are completely and completely are completely and completely are completely are completely and completely are completely are completely and completely are completely are completely are completely are completely are completely and completely are completely are completely are completely and completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are completely are co	majory or other place)
ţim	oermit. Pages Department of I Important: If its any injury or o		' 4 □Donation 5 □ Other (Specify) LOUJO N	PARK 4-8-06 BACTO. MD.  R Name and Address of Facility REDD FUNERAL SERVICE
Ba	Depa Chepa Impo any ir			1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217
Į.	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not en shock or heart failure. List only one cause on each line.  Immediate Cause (Final PROPAGE ACUTE	Interval Between Onset and Death
	/Medical Examiner		resulting in death)  a. Property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and a property and	EMYOCARDIAL INFARCTION UNKNOWN
	LAGIIIIICI	er	Sequentially list conditions, if any, leading to immediate  b. ARTELIO SERVITION Due to (or as a consequence of):	+HYPERTENSIVE CARDIOVASCULAR DISEASE YEARS
4	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
8760,	ate be exe nysician a he burial-i	al Ex	resulting in death) Last  Due to (or as a consequence of):	
687	ficate physics the	edicai	d	
P.O. Box	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To tha Funaral Diractor: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med		□Ectopic pregnancy 23d. Date of delivery □ Other (specify) Month Day Year
	es that igned to be deta	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	<b>V</b>
ord	w require been si should I	eted	DIABETES MELLITUS, TYPE 2	1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown
Records,	ne faw s has b ge 2 s	Completed	HYPERLIPIDEMIA	24a. Was an autopsy findings available prior to completion of cause of death?
Vital	Attanding Physician: The sr death. actor: After this certificate his by the funeral director, page	a)	25. Was case referred to medical	1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)
of V	Physici this ce al direc	To B	examiner?  1 X yes 2 \( \text{No} \)  Hospital: 1 \( \text{Inpatient} \) 2 \( \text{ERVOutpatient} \)	
on o	ding P. h. After funera	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year) Injury	f 28c. Injury at 28d. Describe how injury occurred Work?  M 1 □ Yes 2 □ No
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Ö	urs after urs after red Dirac			
	To the Hospital or Attant within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	(Check only 2   Medical Examiner: On the basis of examination and/or in one)	h occurred at the time, date and place, and due to the cause(s) and manner as stated.  vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To th within To th compl	Me		29d. Date/signed (Month, Day, Year)
•	VI		Natewart, M.D.	D10170 43/2006
	107'		30. Name and address of person who completed cause of death (Item 23a) (Type, D. W. STEWART, M.D. 222	D10790 4/3/2006 Print), COLD SPRING LN. MD. 21210
	Sta		31. Date filed (Month, Day, Year) /32. Dagistrar's Signature	
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			1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	nysicia		PASQUALE FILASETA		APRIL	Day Year 02 2006	7:15 PM
	Medic xamin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deatl	h	4c. County of Death	
_	Aditiiii	C1	HARBOR HOSPITAL	BALTIMORE		N/A	
Fu	neral	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.		9. Birthp	lace (State or Foreign
	ector		163 20 8057   ¹X M 2□ F   80 Yrs.	Months Days Hours Min.	Mar. 11.	1926 Penr	sylvania
			Usual Residence of Decedent				
ylan	4		10a. State 10b. County 10c. City, Town or Lo	ocation		1	Od. Inside City Limits
Z Z	ğ	ż	Maryland   Anne Arundel   Linthio	cum Heights			1 ☐ Yes 2X ☐ No
h the	1	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Cour	try?
h wit	4		107 South Longcross Road	21090		U.S.	
deat	nanicer must be notified at	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Americ Black, White,	
afte	뒤		1 ☐ Never Married 2 🖾 Married 1 🛣 Yes 2 ☐ No	1 ☐ Yes 2 ▼ No Specify:	io riioani, oton	Specify: Whi	
Since	5 W	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: WW II	Tes zgr No specify.		Specify. WIII	
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thin .		p d	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	9	, D. C.	aı · 1 a
gievi	4	5	4 years Elec	tricial Engineer			Chemical Co
9 E 1	event, the Musical	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Ma		
Ment	tic	To	Ralph Filaseta	Lena	a Terlizzi		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.				ng Address (Street and Number or Ru			
and and	er tra		,	outh Longcross Rd			
of He	a fa		20a. Method of Disposition  20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)		c. Location - City or To	wn, State
Pages nent of 1	- A		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Glen Hav	en Mem. Park 4/6	/2006 G	len Burnie,	Maryland
permit. Departm	important: if item 47 te marke eny injury or other traumatic : <u>once</u> .		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility	once Fune	ral Service	e, P.A.
2 80	eny ir		Home M. Ingmisorish 4	001 Ritchie Highw	ay Balti	more, Maryl	and 21225
			23a. Part1. Enter the disease, or pemplications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardia	c or respiratory arres	t,	Approximate Interval Between
Dhua	:-:		Immediate Cause /Final				Onset and Death
	ician dical		disease or condition resulting in death)  a. ADVANCED LU  Due to (or as a consequence of):	NG CANCER WITH	MELKSIK	563	3 MONTHS
	niner		tain cease 100	ALM DISCRET			1 YEAR
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	INAL DISCASE			
<b>D</b>	US:	Examiner	cause. Enter Underlying Cause (Disease or injury				
Xecu	al-tra	Xal	that initiated events resulting in death) Last c. Due to (or as a consequence of):				
3 8	physicien and the burial-transit						
icate	s the	dicai	Q				
Centil	Se a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delive	erv
eath E	for u	ciar	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
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that	ed b) deta		Part II. Other significant conditions contributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
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Ē	pag.	ပ်				ZNo 1 ☐ Yes	3 No
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ding F	unera	5	27. Manner of Death  1 ☑ Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) Injury	Work?	28d. Describe how	injury occurred	
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or At	ا ا	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, si building, etc. (Specify)	reet, factory, office	City or Town,	eet and Number or Rura State)	t Houte Number,
its at	e je						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	ely fi	edical	29a. Certifier (Check only)  Certifying Physician: To the best of my knowledge, dea  (Check only)  Medical Examiner: On the basis of examination and/or in				
the h	the f	led	one) and manner stated.	20a License number		d Date signed (Mosth	Day Your
Vity Vity	000	Σ	29b. Signature and title of certifier	29c. License number		d. Date signed (Month,	
	. 5		Layer M.D	RES 000		TPRIL 02, 2	006
1 1	11		30. Name and address of person who completed cause of death (Item 23a) (Type			2122-	
10	1		LAY KHIN, 3001 SOUTH HANOV	ER ST , BALTIM	IORE, MD	21225	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	land o			
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Physic	ian	1. Decedent's Name (First, Middle, La						2. Date of D Month	D		ear _	3. Time of Death
/Medi	ical	Mary Louise Fr.  4a. Facility Name (If not institution, give		· · · · · ·		Ab City Town o	r Location of Dea	MAR		c. County of		2:00 PM
Exami	ner	Saint Joseph		Cent	er	46. City, Town, o	Tows	on		B.		imore
Funeral Director		5. Social Security Number 6. S 215-28-6009	ex 7. Age	e (In yrs. las 75	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		irth ay, Yea	931	Birthp Coun Mary	lace (State or Foreign to) Land
and w.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
Marylan f show	ţ	Maryland Baltimo	re		R	osedale						1 ☐ Yes 2X No
ih the or 288	Director	10e. Street and Number			<del></del>	10f. Zip Code	01007		10g. C	itizen of Wh		try?
eath w		6406 Hazelwood	AVENUE	Ever in IIS	13 1	Vas Decedent of H	21237		0-	U.S. A		an Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene.  Depertment of Heelth and Mental Hygiene.  Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show pinjury or other traumatic event, the Maclical Examinar must be notified at ance.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 🏋 Divorced	Armed Forces?  1  Yes 2  N  If Yes, Give  Year or Dates:			Vas Decedent of H i Yes, specify Cuba □ Yes 2 <b>X</b> I No	Specify:	no Rican, etc.)	0		White,	
72 hc	etec	15. Decedent's E. (Specify only highest gra	ducation ade completed)		16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo	orking	16b.	Kind of Busi	ness/Ind	dustry
within ene. then	Completed	Elementary/Secondary (0-12) 10th Grade	College (1-4or 5	+)		emaker	a)		Ou	n Hom	2	
e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last,	)				18. Mother's Na	me (First, Middle	e, Maide	n Sumame)		
Menta Menta arked	To	Joseph Lorito					Grac	e DeKa	tow			
12 sho h and 7 is m		19a. Informant's Name/Relationship ( Mrs. Mary Ellen F				g Address (Street Hazelwo					212	
Heelth Heelth tem 27		20a. Method of Disposition	reg lagin	20b. Plac	ce of Dispos	sition (Name of		Date	,	Location - C		
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res that igned b	by Pt	Part II. Other significant conditions of	contributing to death be	ut not resulti	ing in the ur	iderlying cause giv	en in Part I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
w require been sig should b		CLOSTRIDIUM DIFF	ICILE COLI	ris	<del></del>			1 🗆	Yes	21X No 3	☐ Prob	abły 4 □Unknown
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To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of niner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the tir	me, date and place	e, and due to the curred at the time	cause(	s) and mann	ner as st d due to	ated. the cause(s)
To the within To the	Me	29b. Signature and title of certifier	1	~		29c. Licens	e number		29d. D	ate signed (	Month, i	Dey, Year)
0		1 22				D 3	7254		3/	30/	DI	
3		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type, I				1	t		
St.	ate	31. Date filed (Month, Day, Year)	20 00	1SLER ar's Signatur		-	ON MAR	YLAND 3	120	14		
Regist		APR 0 5 2	2006 Benev	ars Signatur	S. A.	ews)						

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	,	artment of <i>rtificate of</i>			giene	16	10443
			1. Decedent's Name (First, Middle, Las	st)	-	h, and the h		2. Date of De	ath Day	Year _	3. Time of Death
	Physici /Medic		LULA MAE FRAI	NCIS				April		2006	1757 M
н	Examin		4a. Facility Name (If not institution, give	1			or Location of De	ath	4c. County	- 6	
			UNION MEMORIAL	HOSPITAL	146.46.4	BALTIMO If Under 1 Year		re la Para d'Air		NA	(0
	Funeral Director		5. Social Security Number 6. Sr 093 - 30 - 0002	ex 7. Age (In yrs.	Yrs.	Months Days			y, Year)	9. Birting	place (State or Foreign htry)
			Usual Residence of Decedent	11		1		06.02.	1934		1410
	how		10a. State 10b. County		ty, Town or Lo					1	Od. Inside City Limits
	e Ma	cto	MD NA	BAL	MORE						1 Ma_Yes 2 □ No
	ith th	Dire	10e. Street and Number	0.15		10f. Zip Code	00		10g. Citizen of		ntry?
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28e-f show the Madical Examinat Turat be notified at	Funeral Director		AVENUE  12. Was Decedent Ever in U	6 12	212		(Consider Van er No	US,	A ce - Americ	an Indian
	Iten de	n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?  1 ☐ Yes 2 🔼 No				(Specify Yes or No erto Rican, etc.)	Bla	ck, White,	
38	al', or	by	3 Widowed 4 MDivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗶 No	Specify:		Specif	y: BLA	CK
ŏ	2 ho	Completed	15. Decedent's Ed (Specify only highest gra			dent's Usual Occu		working.	16b. Kind of B	lusiness/In	dustry
2	thin 7	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	ed)	VOIRING			30
7	ygian ygian yer th		GED	NA	8CHO(	ol bus	DRIVER	In a Climb Middle	BALTIME		County
ng L	be fill d oth	Be	17. Father's Name (First, Middle, Last)	_				lame (First, Middle,	, Maiden Sumar	me)	
ž	hould d Mer mark martic	2	MARSHALL HERRIN  19a. Informant's Name/Relationship (		19h Maili	na Address /Stree	A LIHEA	SMITH  Rural Route Numb	er City or Town	State Zir	Code)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiane. Department of Heelih and Mental Hygiane. Important: if Item 27 is marked other than "natural", or Items 23a or 28e-f show empty injury or other traumatic event, the Macical Examinar must be notified at once.		ROXANNE BOWM		3403				BALTO. N		
<u>ම</u>	Hee Hee		20a. Method of Disposition	20b. i	Place of Dispo	osition (Name of matory or other pl		Date	20c. Location		
e E	Page: ent o nt: #		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Hemoval from State	BUTUS	matory or other pr		08.06	BALTIMO	ORE	, MD
Baltimore,	permit. Departm Importa eny Inju		21. Sign ture of Funeral Service Licen			2. Name and Add		FUNERAL S	REDUICE		
m	88 5 8		2 aughn C	) —	5	151 BALTO	NATU PI	KE, BALTO	. Mp 21.	229	
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused the dear one cause on each line.	th. Do not en	ter the mode of dy	ring, such as card	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Jan.	Physician		Immediate Cause (Final disease or condition	a Atheroso	cleratr	c Cardi	D vasco	la Dise	جريو		1040
ĺ	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):						(
		-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	uence of):						
(4)	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	,	,						
ć	exection and ital-tra	Еха	that initiated events resulting in death) Last	Due to (or as a consec	quence of):						
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မ	ng ph as th	Wed	IF FEMALE:								
Вох	death certifica attending pl	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta	al death 3[	□Ectopic pregnan	су			ate of delive	ery Day Year
o.	he de	/slc	1 ☐ Yes 2 X No 9 ☐ Unknown	4∏Pregnant at time of o 9☐ Unknown	death 5[	Other (specify)					
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Sor	w requir been si should	lete	Acute los	al failure				24a. Was	an 24b.	Were auto	posy findings available
Be	he la e has age 2	Completed	7/00/0 1-400	1 141 100 0					ormed?	prior to co death? 1 \( \text{Yes} \)	opsy findings available impletion of cause of
ta	an: T tificat tor, pa	BeC	25. Was case referred to medical				26. Place of D	1 Yes Death (Check only	2 No	1 105	2   NO
<u> </u>	Physician: this certifica ral director, p	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	] ER/Outpatie	nt 3□ DOA	thor	g Home 5 ☐ Resi		her (Specia	(y)
0	ng Ph ter th neral		27. Manner of Death 1/SANatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Inj	ury at ork?	28d. Describe	how injury occu	rred	
Sio	Attending it death.  ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				JYes 2 □No				
Division of Vital Records,	after d Direct In by I	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, st fy)	reet, factory, office	8	28f. Location ( City or To	Street and Num. wn, State)	per or Run	al Route Number,
۰	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledne dea	th occurred at the	time, date and nis	ace, and due to the	cause(s) and m	anner as s	stated.
	To the Hospitel within 24 hours a To the Funerel I completely filled	edicai		niner: On the basis of examinand manner stated.	ation and/or in	nvestigation, in my	opinion, death of	ccurred at the time,	date and place,	, and due t	o the cause(s)
	To th Within To th	Σ	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date sign	ed (Month,	Day, Year)
			N.M M.J	)_		AT 2	43894	16	41	2/2	206
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type	, Print)	, 11	A I N	18		
	(		N. M. E. Manes	1 1	on M	emaria.	1 40>1	pital 1	17		
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Sign	ALUITO A	estel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 3 Richard 2 06 10:45 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 1293 Hardy Road Arnold Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. NOV • 24 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1<sup>Y04[)</sup>924 XIXM 2□F Maryland 218-14-3113 81 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 ☐ No Maryland Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1293 Hardy Road 21012 12. Was Decedent Ever in U.S.
Armed Forces?

12 Yes, 2 □ No
If Yes, Give
Year or Dates: 1943-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Black 1 ☐ Yes 2 A No Specify: Specify 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer 3rd St. John's College 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Ford Lavinia Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Spears (Daughter) 55 East Joyce Lane Arnold, Md. 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Bestgate Memorial 4 ☐ Donation 5 ☐ Other (Specify) 3/31/06 Annapolis, Md. 22. Name and Address of Facility
Wm. Reese & Sons Mortuary, 1
821 west St. Annapolis, Md. 21. Signature of Funeral Service Licenses 1 DiTreeso MOO 983 Lavor 23a. Part1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart f silure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final cance prostate disease or condition resulting in death) VEOU Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 221No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one, Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Actural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 11. Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ettending physicien for use as the buria ed by the e this or Attending death. after death the filled in by within 24 hours a To the Funerei

**Physician** 

/Medical

Examiner

Directo

Completed by

Be

**Funeral** 

Director

Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event. The Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mentat Hygiene. Important: If Item 27 is marked other then "natural", or Itemas 23a. eny hjury or other traumatic event, the Medical Examiner must bonce.

**Physician** 

/Medical

Physician/Medical

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Completed

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Certification:

Medicai

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Examiner

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar emmen

82. Registrar's Signature

cause of death (Item 23a) (Type, Print)

29c. License number D0059173 29d. Date signed (Month, Day, Year)

.28.06

				1 - For State Ragistrar	State of Ma		/ Depa		t of H	ealth and	-	giene	) 6	0445
		Physici		Decedent's Name (First, Middle, Last)							2. Date of Do		Year	3. Time of Death
		Physici /Medio	al	Elsie Margaret Fos				45 025	<b>.</b>		Marc	h 28,6	2006	4:35 PM
		Examir	ier	4a. Facility Name (If not institution, give stress SALISBURY REHAB & N		ENTER				Location of De		4c. County		
	*	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. las	t birthday)	If Under Months	1 Year	If Under 24 H	s. 8. Date of Bi	dh		ce (State or Foreign
	秀	Director		231-28-8844	4 2∑F	90	Yrs.	W.Gittino	Duyo	110013	July 3	1, 1915	Mary!	
		yland 10W		10a. State 10b. County		10c. City,	Town or Lo	cation					100	I. Inside City Limits
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_	)	within 72 hours after death with the Maryland ene. then "natural", or iteme 23s or 28s-f ehow to Macical Exemiter chart by motified at	Be Completed by Funeral Director	10e. Street and Number 34831 Railroad Ave	nue			10f. Zip	Code	21850		10g. Citizen of V	What Country JSA	y?
9	/	teme	uner		. Was Decedent E Armed Forces?		13. V	Vas Deced Yes, spec	ent of His	spanic Origin? n, Mexican, Pue	Specify Yes or N into Rican, etc.)	o- 14. Rad Blad	e - American	
SX	5-0036	72 hours afte natural', or i	d by F	1 Never Married 2 Marned 3 Widowed 4 Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	)	1	I□Yes 2	2∏ No	Specify:		Specify	whit	:e
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0)	ryla	should be nd Mental marked o	2	Charlie Francis Da			10h Maille		(5		Margaret		C4- 4- 7'- 0	
5	Mary	nd 2 shoulth and 27 ie mu		Harvey Foskey/son	, Pnnt)			-			Rural Route Numb Pittsv:			
-	Baltimore,	ges 1 and 2 should be filed tof Health and Mental Hyg If item 27 is marked othe or other traumatic event,		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren	noval from State	20b. Plac	e of Disponentery, crem	sition (Nan	ne of ther place	)	Date	20c. Location -	City or Town	n, State
$\alpha$	tim	permit. Pages Department of i Important: If it any injury or o		4 Nonation 5 Other (Specify)		7	T							
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		be executed icien and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (oπ as∕a	consequer	nce of):		29.0				4	2004
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	Вох	ath ce attendi for use	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of	Fetal de	eath 3	Ectopic pro					te of delivery inth Da	
	P.0.	the de	nysic	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at ti 9□Unknown	me or dear	tn 5	Other (sp	эспу)					
	ds, P	Hospital or Attending Physician: The law requires that the death certifica is hours after death. Funeral Director: Atler this certificate hes been signed by the attending phiciply filled in by the funeral director, page 2 should be detached for use as the last the funeral director.	d by Physician/Med	Part II. Other significant conditions contri	buting to death but	not resulti	ng in the ur	nderlying ca	ause give	n in Part I.		tobacco use cont	-	cause of death?
	SCOI	ław requir es been s 2 should	Completed								24a. Was		Were autops	y findings available
	I Re	The tage page	Com								auto perf 1 ☐ Yes	ormed?	death? 1 🗌 Yes 2	letion of cause of
	Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:				Othe	. /	eath Check only			
	ō	ding Physician:  After this certific funeral director,	n: To	27. Manner of Death	28a. Date of Injury	21	8b. Time of		Bc. Injury Work	4 Janursing	Home 5 ☐ Res 28d. Describe	idence 6 Oth how injury occur		
	ion	tending Falsath.	atio	1 Matural 5 Pending 2 Accident investigation	(Month, Day	rear)	Injury	М		es 2□No				
	Division of Vital Records,	ii or Attendir after death. Director: Af I in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y - At home (Specify)	e, farm, stre	et, factory	, office			Street and Numb wn, State)	er or Rural F	Route Number,
		To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1 Madical Examine	ian: To the best of r: On the basis of e and manner state	examination	edge, death n and/or inv	occurred a	at the time in my op	e, date and pla inion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as state and due to th	ed. ne cause(s)
		To the within To the comple	Me	29b. Signature and title of certifier	1//			29c	. License	number		29d. Date signe	d (Month, De	y, Year)
				MA	2			2	02	539	9	5/30	186	
				30. Name and address of person who com WILLIAM ROBINS, M.I	200 41	****	T 777	CATTO	BURY	Z, MD.	21804	1		
	4	Sta	te	31. Date filed (Month, Day, Year)  APR 0 5 2006	82. Registrar	's Signatur	· 1084	W		-,				
	1	Registr		MPR 0 5 2006	Comme	100								

			1 - For State Registrar	State of Marylan	d / Depa	artment		d Mental Hyg		06	10446
	Physici	an	1. Decedent's Name (First, Middle, Last,		2.5			2. Date of Dea Month	Day	Year July C.	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give			4b. City, To	own, or Location of D	Death	4c. Co	unty of Death	1. 201) 1
	Funeral Director		5. Social Security Number 6. Sec 218-60-3239	1.1		If Under 1	Year If Under 24	Hrs. B. Date of Birth (Month, Day May 2, 1	h /. Year)	9. Birthp Coun Mary	lace (State or Foreign try) and
land	Mo #		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	Od. Inside City Limits
e Mary	if and	ctor	Md, NA		Ba	ltimore					1 Ves 2 □ No
with th	Nor 28	Director	10e. Street and Number			10f. Zip C				of What Coun	try?
death	THE 23	Funeral	1406 W. Frankli	12. Was Decedent Ever in U.	.S. 13.		121/ nt of Hispanic Origin	? (Specify Yes or No- cuerto Rican, etc.)		USA Race - Americ	an Indian,
Maryland 21215-0036 Id 2 should be filed within 72 hours atter death with the Maryland	iene. r then "neturel", or iteme 23a or 28a-f show Ihe Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		If Yes, specif		Puerto Rican, etc.)		Btack, White, ecify: Bla	
15-C	"neto	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual kind of work	Occupation done during most or retired)	working	16b. Kind	of Business/Inc	lustry
2121	r then	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Housev		romou)			Domesti	С
<b>D</b>	d other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sui	mame)	
<b>S</b> loud	narke natic	٩	Frank Graham	ma (Print)	40h 44-11			Eva Graham	- C' - T		
Ma Id 2 st	Ith and 27 ie r treur		19a. Informant's Name/Relationship (Ty Shantera Flowers/ Gra					Baltimore, N	-	•	Code)
<b>re</b> ,	of Heelt fitem 2 r other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name	of	Date		ion - City or To	wn, State
<b>Baltimore,</b> permit. Pages 1 av			1 XBurial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	removal from State	Zion Ce	•	1	-07 <b>-</b> 06 I	Lansdow	ne. MD	
<b>Bait</b>	Depart Import eny inj pnce.		21. Signature of Funeral Service Licens	99			Address of Facility				more, MD 2121
1	sician and Medical xaminer	Examiner	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Gostons that caused the deather cause on each line.  Due to (or as a consequence).  Due to (or as a consequence).	uence of):	ter the mode	of dying, such as ca		rest,		Approximate Interval Between Onset and Death
HECOLOS, P.O. BOX 08/00/	> @	Physician/Medical Ex	IE EEMALE:	Due to (or as a consequent.  23c. If yes, outcome of pregnation of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the consequence of the	ancy	□Ectopic pred			23d	Date of delive	ry Day Year
uires that	n signed by	by	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	inderlying cau	se given in Part I.		bacco use		e cause of death?
		Completed				-		24a. Was a autop perfor 1 Yes	sv	prior to cor death?	osy findings available inpletion of cause of
Of Vita Physician:	is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Other	Death (Check only or			-
o g	th. : Atter this : funeral di	tlon; To	1 Yes 2 M6  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		thijury at Work?  1 ☐ Yes 2 ☐ No	ng Horne 5 - Resid			")
	s after deett il Director: id in by tha	Certification;	3 Surcide 4 Homicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str y)	reet, factory,	office	28f. Location (S City or Tow		umber or Rura	l Route Number,
U. he Hospital or	within 24 hours after deeth.  To the Funerei Director: After completely filled in by tha funer	edical	29a. Certifier Certifying Physical Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at vestigation, ii	the time, date and p n my opinion, death	place, and due to the opecurred at the time, o	cause(s) and date and pla	d manner as st	ated. the cause(s)
D <sub>for</sub>	within 2 To the complei	W	29b. Signature and title of certifier	× M	D		License number	Saltimo		gned (Month, I	
	7		30. Name and address of pirson who co	41 821	*	Print)	ust. E	altima	L M	D7-1:	20/
	Sta Registi		31. Date filed (Month, Day, Year)  APR 0 5 21	32. Begiltrar's Signa	IN A	and)					

			riedse i	State of Manyland / Dor		-	•
			For State	State of Maryland / Dep	ertificate of Death		1900 INT. 1.7
			Registrar  1. Decedent's Name (First, Middle, Last)		Fillioate of Death	2. Date of Deat	h 3. Time of Death
	Physici	an		Jean Ford		Month	Day Year
	/Medic		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Death	04/01/	/ 2006 8:37 a <sup>M</sup>
	Examin	ıer	Southern Maryla		Clinton		Prince Georges
	Funeral		5. Social Security Number 6. Sex		) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	
	Director		578-52-3654 <sup>1□</sup>	M 280 F 70 Yrs.	Months Days Hours Min.	06/17	1935 DC
	P		Usual Residence of Decedent				
	arylar show	_	10a. State 10b. County	10c. City, Town or I			10d. Inside City Limits 1 ▼Yes 2 □ No
	8e-f	ecto	MD Prince G	eorges Temple			
	with the	Dir	10e. Street and Number 2212 Iverson St	reet	10f. Zip Code 2 0 7 4 8	11	Og. Citizen of What Country? U.S.A.
	be filed within 72 hours after death with the Maryland Hygiene. d other then "naturel", or items 23a or 28e-f show event, the Medical Examiner must be natified at	by Funeral Director				acify Vas or No.	14. Race - American Indian,
	ter d	E	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black White etc
936	urs al	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify.Black
Ģ	2 ho	ted	15. Decedent's Edu	cation 16a. Dec	edent's Usual Occupation	lein n	16b. Kind of Business/Industry
215	thin 7 en "r Mad	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	(ing	
2	filed with Hygiene. ther ther	Completed	11	Rese	archer		Government
nd	be fill tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)  John H. William			ne (First, Middle, M	Maiden Sumame) Lse Marshall
₹		ပ္					
Maryland 21215-0036	s 1 and 2 should f Health and Mer item 27 is marke other treumetic		19a. Informant's Name/Relationship (Ty		ling Address (Street and Number or Ru		
ത്	s 1 and 2 if Health item 27 i		William Ford/ H 20a. Method of Disposition		2 Iverson St.Te		LIIS, MD 20748 20c. Location - City or Town, State
ק	nf of I		1 ☑ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	ematory or other place)		
Baltimore,	it. Pr trime trient njury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fuperal Service License				Landover, Maryland
Ba	permit. Pages Department of h Importent: If ite any injury or of once.						II Funeral Chapel
			23a. Part1. Enter the disease, or compli	ications that caused the death. Do not en cause on each line.	0583 Middleport nter the mode of dying, such as cardiac		
	Physician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	ACUTE MYOCARDI  Due to (or as a consequence of):	AL INFARCTION		
	Examiner						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	nd nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	: :			
,092	e exe	Ä	resulting in death) Last	Due to (or as a consequence of):			
876	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai		d			
x 68	entific ding page as	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy			
Вох	atten for us	lan	in the past 12 months?	1 Live birth 2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	he de	ysic	1 □ Yes 2 ② No 9 □ Unknown	9 Unknown	□ Ottler (specify)		
P.O.	that the de ned by the a detached		Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death?
Records,	uires sign ld be	d by	Diabetes			1 □ Ye	s 2 No 3 Probably 4 Unknown
00	w require	lete	Hypertension			24a. Was a	24b. Were autopsy findings available
Re	The lav	Completed	пурогос			autops perforn	y prior to completion of cause of death?
		a	25. Was case referred to medical		26 Place of Dea	1 ☐ Yes 2 th (Check only on	HONo 1 □ Yes 2 No
<u> </u>	S S	0	examiner?	lospital: 1 Inpatient 2 ER/Outpatie	Othor		nce 6 ☐Other (Specify)
	a to le	Ë	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at	28d. Describe ho	
Ö	Attending I ir death. ector: After by the funer	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(manu, bu) rous, mijus,	M 1 ☐ Yes 2 ☐ No		
	or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St. City or Town	reet and Number or Rural Route Number, , State)
	itel o irs aft rel Di lled ir					<del> </del>	
	To the Hospitel or Ai within 24 hours after of To the Funerel Direc completely filled in by	edical	(Check only 2 Medical Examin	sician: To the best of my knowledge, dea ner: On the basis of examination and/or i	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the ca rred at the time, da	tuse(s) and manner as stated.  Ite and place, and due to the cause(s)
	To the I within 2 To the I complet	Med	one)  29b. Signature and title of certifier	and manner stated.	29c. License number	29	ed. Date signed (Month, Day, Year)
	Z N N N N N N N N N N N N N N N N N N N		200, digitatoro and title objectives				
,	0		730	ampleted cause of death (here only)	D40324		April 3,2006
j	0			ompleted cause of death (Item 23a) (Type D 7503 Surratts		vland 2	0731
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signature		,	
	Registr		APR 0 5 200	37 Registrar's Signature	eres.		

Registrar

DHMH 17 Rev 1/2001

APR 0 5 2006

			1 - For State Registrar	State of Ma	-	oartme		ealth a		ental Hyg	_	5	0449		
	Plant	***	1. Decedent's Name (First, Middle, Last	)						2. Date of Deat Month	h Day	Year	3. Time of Death		
	Physici /Medic		SARAH ELIZA KEY	GROFF					N	March 31			11:30 p.	1	
	Examir		4a. Facility Name (If not institution, give					Location of	f Death		4c. County	,	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s		
		te.	Roland Park Place				altimo		2411-		n/				
	Funeral		5. Social Security Number 6. Se 217–16–4594	x 7. Age ∃M 257F	(In yrs. last birthda 89 Yrs.	y) If Und Month	er 1 Year s Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, July 28	Year)	Cou	place (State or Foreig	m	
-38	Director		Usual Residence of Decedent	Λ	09 113.					July 20	,1910	Mary	yland		
	land ow		10a. State 10b. County		10c. City, Town or	Location							10d. Inside City Limit		
	Man,	ţ	Maryland n/a		Baltimo	re							1 ☐ Yes 2 ☐ No	3	
	r 28a	Directo	10e. Street and Number				ip Code		.,	1	0g. Citizen of	What Co	intry?		
	h wit	ai D	830 W.40th Str	eet			21211				U.S.	A.			
	deal	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13	3. Was Dec	edent of Hi	spanic Orig	gin? (Spec	cify Yes or No- lican, etc.)		14. Race - American Indian, Black, White, etc.			
9	or Its		1 Never Married 2 Married	1 ☐ Yes 2 X No			21X No		, 1 401.01.	110411, 010.7	Specif		, 813.		
8	ural',	d b	3 Widowed 4 Divorced	Year or Dates:			27.10	оросту.				W	hite		
N.	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f show ha Modical Exeminer must be notified at	Completed by	15. Decedent's Edu (Specify only highest grad		(Gi	ve kind of v	ual Occupa vork done d	turing most	of workin	g	16b. Kind of Business/Industry				
12	withir sne. than	E G	Elementary/Secondary (0-12)	College (1-4or 5+	)	Secre	use retired,	,			Private School				
d 2	Hygi ther ther		17. Father's Name (First, Middle, Last)			DECLE	Lary	18. Mother	r's Name	(First, Middle, I			HOOT	_	
a	ould be Mental arked o	To Be	John		Grof	E		San	rah			S	heeler		
Maryland 21215-0036	2 should be and Menta is marked aumatic ev	1	19a. Informant's Name/Relationship (T)	vpe, Print)			ss (Street a	-		Route Number	City or Town,				
M	nd 2 s lith ar 27 is r trau		John McCann (P.R.)			-				ville,	-				
ē,	f Health item 27 i	1 K Burial 2 Cramation 3 Removal from State   cemetery, crematory or other place)									20c. Location				
9	Pages nent of int: If it iry or o	로탈탈 4 Donation 5 Other (Specify) Druid Ridge Cemetery 4-6-06							)6 ]	Marvland					
Baltimore,	Druid Ridge Cemetery 4-6-06  21. Signature of Funeral Service Likensee  22. Name and Address of Facility Mitchell-Wiedefeld I 6500 York Road Balt														
m	Ded on o		Colect Tono	4		(11	5500 S	Cork R	edere Road	Baltimo	re.Mar	vlan	1 21212		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused to	he death. Do not e	enter the m	ode of dying	g, such as c	cardiac or	respiratory arri	est,		Interval Between		
la de	Physician		Immediate Cause (Final disease or condition		umon	18							Onset and Death	7	
	/Medical		resulting in death)	α	consequence of):	- \					-		t week	-	
В	Examiner		Sequentially list conditions,	b											
200	p <sub>B</sub> #s	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):										
	ate be executed hysicien and he burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);							-			
760,	be eg	cai E													
687	icate phys s the			d											
Box (	eath certificat attending phy I for use as thi	N/A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							23d. Da	te of deli	verv		
ă	death a atte	ciai	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		B⊟Ectopic 5⊟ Other (			_			onth	Day Year		
P.O.	t the de by the a	Physician/Med	9 Unknown	9□ Unknown											
	The law requires that the death certifica ate hes been signed by the attending ph bage 2 should be detached for use as it	by P	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying	cause give	on in Part I.		23e. Did tot	oacco use con	nbute to	the cause of death?		
Vital Records,	w require been sig should b	pa	Dement	E - A!	esum	el	Alz	chei	mes	1 □ Ye	s 2 No	3 🗆 Pro	bably 4 Unknow	n	
900	law request been 2 should	24a. Was an autopsy findings availab													
Ě	The I	Completed								perforr	ned?	death?			
ita	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	180.000				26. Plac	of Death	Check only on	e/				
of \	Physic this ca	၉	1 ☐ Yes 2 ☑ No	Hospital: 1 🔲 Inpatient	2 ER/Outpat	ent 3 🗆 [	DOA Othe	er: 4 Nur	rsing Hom	e 5 Reside	nce 6 Oth	er (Spec	ıfy)		
ū		on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time	/	28c. Injury Work	ς?		8d. Describe ho	w injury occur	red			
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Division	or Attend after death Director: /	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At nome, farm, (Specify)	street, facto	ory, office		2	City or Town	reet and Numt n, State)	or or Hu	ral Route Number,		
_	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 ☐ Certifying Phy	sician: To the best of	my knowledge de	ath occurre	ed at the time	ne, date and	d place a	nd due to the o	ause(s) and m	anner ae	stated		
	e Hos	Medical		ner: On the basis of e	xamination and/or	investigation	on, in my or	oinion, deat	h occurre	d at the time, d	ate and place,	and due	to the cause(s)		
	To the within 2. To the f	M	29b. Signature and title of certifie	5 /		2	9c. License	number		2	9d. Date signe	d (Month	, Day, Year)		
			► William	mylo	ner	~		421	29		Apri	1 4	1,2006		
1	2		30. Name and address of person who c	ompleted cause of dea	ath (Item 23a) (Typ	e, Print)				- i	0	h 3	1,2006		
1	1		William D.	Mc Co-	nells	2	63	01 1	V. (	Charle	1 B	a 1+	more		
100 g 4	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar	s signature	Coast	20								

			For State Registrar	State of Marylan		artment of I			giene eg. No. 006	0450
	Physici /Medic		1. Decedent's Name (First, Middle, La	Gardner	,		-	2. Date of Dea	th Day Year	3. Time of Death 7-28A M
	Examir		4a. Facility Name (If not institution, giv	e street and number)		Balt	r Location of Dea	th	4c. County of Deat	1.
	Funeral Director		5. Social Security Number 6. S  218-18-0109  Usual Residence of Decedent	ex 7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days			9. Birth 3, 1921 MA	hplace (State or Foreign puntry)  RYLAND
	Ba-f ehow	Director	10a. State 10b. County  MARYLAND	10c. Cit	y, Town or Lo	BALT	IMORE	1	/	10d. Inside City Limits 1 X Yes 2 □ No
	death with the Maryland ims 23a or 28a-f ehow	Funeral Dire	10e. St/eet and Number  1102 DRUID  11. Marital Status	12. Was Decedent Ever in U	NUE- .s. 13.	10f. Zip Code Was Decedent of i	2/2 Hispanic Origin?	Specify Yes or No- no Rican, etc.)	0g. Citizen of Whal Co USA 14. Race - Ame	ł
9003	72 hours after netural; or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1		1□Yes 2爲No	Specify:	nto Hican, etc.)	Specify: B	LACK
21215-0036	within 72 liene.	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ide completed)  College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occu kind of work done DO NOT use retire SEA M.	pation during most of world)  STRES		16b. Kind of Business/	
Maryland 2	ould be filed Menfal Hygi arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last, EVA-N	Ja	NE	5		me (First, Middle, i		. /
Baltimore, Mar	Pages 1 and 2 should be filed within 72 hours after death with the Marylan pent of Heelih and Merial Hygiene. In the filed marked other than "netural; or items 23a or 28a-1 show int: if tem 27 is marked other than "netural; or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (  CLORES ALEXANNER = 20a. Method of Disposition   Surial 2 Cremation 3   4 Donation 5 Other (Specific Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Processing Proce	TO NES DAUGHTER 20b. F	lace of Dispo emetery, crei	7 2 .7 .	GILMOI	2 ST. K	7, City or Town, State, 2 3ALTO M 20c. Location - City or	1021217
Baltin	permit. Pag Depertment Important: eny injury once.		21. Signature of Fun ral/Service Licer			2. Name and Address		ROWN THE	R. FUNERI BALTO. 1	AL HOME MD. 21217
	Pnysician /Medical		3a. Part1. Enfer the disease, or com shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death one cause on each line.	h. Do not en	er the mode of dy	ng, such as cardia	c or respiratory arm	est, UPC	Approximate Interval Between Onset and Death
, A	execufed  an and rial-fransit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Que to (or as a consequence to (or as a consequence to (or as a consequence do do do do do do do do do do do do do	ve h uence of):	egit chz (	Faile	ure Jas.di	Sex	
Box 6	death certif e affending od for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3[	Ectopic pregnanc Other (specify)	у		23d. Date of deli Month	ivery Day Year
	law requires that the es been signed by th 2 should be defache	þ	Part II. Other significent conditions of	ontributing to death but not resi	ulting in the u	nderlying cause gr	ven in Part I.		pacco use contribute to	
Œ	: The faw re cefe hes bee page 2 sho	Completed	5- <b>4</b> -41 - 5-3-3-3-3-3-3-6					24a. Was a autops perform	y prior to d	topsy findings available completion of cause of
Zit	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	. aCI DOA Ott		ath Check only on	ence 6 Other (Spec	
ion of	Attending Phy ir death. ector: Affer this by the funeral c	F 7	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju. Wo		T	ow injury occurred	city)
Divis	5 th 6	Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify	<i>(</i> )			City or Towr		
	To the Hospital within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the bast of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	vestigation, in my o	opinion, death occ	e, and due to the et urred at the time, d	auto(s) and manner as ate and place, and due	to the cause(s)
	To th To th COMP	Me	29b. Signature and title of certifier	4 Modern	MD	29c. Licens	se number	03 5	9d. Date signed (Month	2006
	17		30. Name and address of person who	MAEAN 5	4 De	lphin	St, t	Salta 1	MD ak	12
	Sta Registr		31. Date filed (Month Pay, Year) APR 0 5 2	32 Registrar's Signa	The state of	sel.				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1825 M Koman Anthony, Guer C10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore medical BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, V DEC . 11, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1**X** M 2□ F 218-22-2649 79 Director 1926 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28e-f ahow the Madical Examiner must be notified at MARYLAND ANNE ARUNDEL 1 ☐ Yes 2 No ODENTON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1458 BERGER ST. 21113 UNITED STATES filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ If Yes, Give Year or Dates: WW 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MECHANIC AUTOMOTIVE i. Pages 1 and 2 should be filed witnest of Health and Mental Hygie tent: If Item 27 is marked other 1 jury or other traumatic avant, In other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOACHIM GUERCIO GERTRUDE HARRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN GUERCIO / WIFE 1458 BERGER ST., ODENTON, MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State APRIL 7, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. 4 □ Denation 5 □ Other (Specify) MEADOWRIDGE MEM. PK. 2006 ELKRIDGE, MARYLAND 21. Signat he of Foge al Servi e Licensee Name and Address of Facility
RKLEY-RUDDICK FUNERAL HOME, P.A.
1 CRAIN HWY., S.E., GLEN BURNIE, 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10gen16 /Medical Due to (or as a conseque Examiner ocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Mospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 Yes 2 No 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No has 1 ☐ Yes 2DNo 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending Injury 1 Yes 2 No death. I Diractor: / 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours efter To the Funeral Dire 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier anne address of person who completed cause of death (Item 23a) (Type, Print) 22 South Green St. eanne tin MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 5 2006 Boork Registrar

		1 - For State Registrar	State of Maryland / I	Department of Healt  Certificate of Dea		giene 006	10452
Physic		1. Decedent's Name <i>(First, Middle, Las</i> Lester	Price	Hamrick	2. Date of De Month MARCI	Day Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give Union Memorial H	· ·	4b. City, Town, or Locat Baltimo:	tion of Death re	4c. County of Dear	
Funera Directo		5. Social Security Number 6. Se 251–03 2732 10 Usual Residence of Decedent	7. Age (In yrs. last bi	rthday) If Under 1 Year If Ur Months Days Hou	nder 24 Hrs. 8. Date of Bir (Month, Date of Bir (Month, Date of Bir 9-25-	ay, Year) Co	hplace (State or Foreign buntry) S.C.
the Maryland r 28a-f ehow	Director	10a. State 10b. County Md. NA  10e. Street and Number	10c. City, Tow Ba	n or Location  Ltimore  10f. Zip Code		10g. Citizen of What Co	10d. Inside City Limits 1X Yes 2 □ No puntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28s-1 show any injury or other traumatic event, the Macacal Examinar must be notified at	Funerai	1.628 N. Milton A  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Ve •  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	21213  13. Was Decedent of Hispanic If Yes, specify Cuban, Mexing 1 1 Yes 2 1 No Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Specific No. Sp	xican, Puerto Rican, etc.)	Black, Whit	
Maryland 21215-0036 d 2 should be filed within 72 hours all th and Mental Hygiene. 77 ie marked other than "natural, or traumatic event, the Mudical Exam	Completed by		ucation 16a	Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)  Pastor		16b. Kind of Business	_ •
yland  puld be fil  Mental H  arked ott  atic even	To Be	17. Father's Name (First, Middle, Last) Albert	Hamri		Mother's Name (First, Middle	, Maiden Sumame) Stamey	
and 2 shu and 2 shu ealth and m 27 le m		19a. Informant's Name/Relationship (T Alice Hamrick	Wife	. Mailing Address (Street and Nu 1628 N. Milton	Ave., Baltim	ore, Md.	21213
Baltimore,  bermit. Pages 1 ar Department of Hea mportant: If Item: mng, injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State cemete	f Disposition (Name of ry, crematory or other place) Y Hills Cem.	Date 4-8-06	20c. Location - City or Middle Rive	
Balt permit. Departi Import any inj		21. Signature of Funeral Service Licens	n Warre	22. Name and Address of F March F.H.	East 110	Baltimore, B Ol E. North	Md. 21202 Ave.
Physician /Medica	_	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. SEPSIS		h as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death 3 DAYS
ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence  SMACL BOV  Due to (or as a consequence  C. Due to (or as a consequence	OF PNEUMO			3 DAYS
O. BOX ( the death certif the attending ched for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome of pregnancy 1	3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	ivery Day Year
dS, P,	5	Part II. Other significant conditions co	ntributing to death but not resulting i	n the underlying cause given in P		obacco use contribute to Yes 2 □ No 3 □ Pr	
DIVISION Of VITAI RECORDS, to Attending Physician: The law requires the death.  Director: After this certificate has been signed in by the tuneral director, page 2 should be to	Completed				24a. Was auto peric 1 □ Yes	psy prior to death?	Itopsy findings available completion of cause of
VITA sician: certific irector,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 12   Impatient 2   ER/O	Other	Place of Death (Check only	one)	
SION Of VITA  tending Physician: leath.  tor: After this certific the funeral director,		27. Manyler of Death  1 Matural 5 Pending  2 Accident investigation	28a. Date of Injury 28b.	Itine of injury M 1 Yes 2		how injury occurred	offy)
DIVIS all or Atte s after der li Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location ( City or To	Street and Number or Ru wn, State)	ıral Route Number,
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical (	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medical Exam	rsician: To the best of my knowledge iner: On the basis of examination are and manner stated.	e, death occurred at the time, dated/or investigation, in my opinion,	te and place, and due to the death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the withing To the the the the the the the the the the	×	29b. Signature and title of certifier	seneon M.T	29c. License numb	8946F13	29d. Date signed (Mont.) MAILCH 3	
1/			NGAR M.	D. UNION	U MEMORIA	-C HOSPIT	AL, MD.
Regis		31. Date filed (Month, Day, Year)  APR 0 5 2	32. Registrar's Signature	Specific			
DHMH 17 Rev 1/	<b>20</b> 01			RIGINAL			

			, FOI	epartment of Health and	Mental Hygie	ne006	0453
			Registrar	Certificate of Death	Reg.	No.	2 Fire of Death
	Physicia	an	1. Decedent's Name (First, Middle, Last)  MATE, LOUISE, HYNSON		Month	Day Yeer	3. Time of Death
	/Medic	al			April 0	4c. County of Death	1/0:351 **
	Examin	ier	4a. Facility Name (If not institution, give street and number)  [HAR BOR I HOSPITAL CENTER	4b. City, Town, or Location of Death	_	N/A	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho				place (State or Foreign ntry)
	Funeral Director		213 14 2491 1 M 2 X F 86 Yr	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye) Feb. 12,		vland
	ס		Usual Residence of Decedent		12,		
	how	_	10a. State 10b. County 10c. City, Town of				10d. Inside City Limits
	Ba-f e	cto	Maryland Anne Arundel Balti	more			1 Tyes 2 No
	ith th	Funeral Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	ntry?
	ath w	B	104 - 3rd Avenue	21225			
	er de Item	une		<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> </ol>	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White	
5	rs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No If Yes, Give 3 ☐ XWidowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	.te
2-003p	ture sture	ed	15 Decedent's Education 16a. D	ecedent's Usual Occupation	16b	. Kind of Business/Ir	ndustry
2	in 7	pie	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	Give kind of work done during most of wor fe. DO NOT use retired)	rking	. 1 D	1: T
7	giene giene	Completed	11th	ncession Stand Oper	rator	outnway Bo	wling Lanes
2	al Hy al Hy I oth	Be	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid	den Sumame)	
yland	Ment Ment arked atic e	2	J. Croyden Tice	May	Reed		
Mar	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  le marked other than "neture!", or itema 23a or 28a-f show sumatic event, it is Mudical Examinar must be multified at		1 1 2 1	Mailing Address (Street and Number or Ru			
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<u> </u>	ges it of H if ite or of		I LE DUTAL 2 Cremation 3 Chemoval from State	isposition (Name of crematory or other place)		. Location - City or T	
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ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylen Deperment of Health and Mental Hygiene. Important: If them 27 is marked other then "neturel", or itema 23a or 28a-f show eny injury or other traumatic event, it is marginal Examinar must be multilast at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility G 4001 Ritchie Highw	once Funer av Baltim	al Servic ore. Marv	e, P.A. land 21225
Ħ			23a. Part1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. Alst only one cause on each line.			, , , , , ,	Approximate Interval Between
ı	Physician			ROVASCULAR ACC	IDTIVIT	-	Onset and Death
	/Medical		disease or condition resulting in death)  Due to (or as a consequence of)	-	196141		three days
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	ס ≒	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
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700,	ate be executed hysicien end the burial-transit	icai E	resulting in death) Last Due to (or as a consequence of)				
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ň	death le etter	ciai	in the past 12 months?  1 Ves 2 No.  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
j.	t the by the ache	Physician/Med	9 Unknown				
ທົ	The law requires thet the death certificate ate has been signed by the ettending phys page 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to	
SLGS,	en sig		CORONARY ARTERY DISEASE		1 🗆 Yes	2 □ No 3 1 Pro	bably 4 □Unknown
oco	lawr as be 2 sh	Completed	DIABETES MELLITUS		24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
<u> </u>	The ete h page	Con	CONGESTIVE HEART FAIL	IRE	performed	l? death?	2 □ No
Vital	cien: ertific actor,	Be	25. Was case referred to medical	26. Place of Dea	ath (Check only one)	•	
5	Physic this c	은			lome 5 Residence		fy)
	Jing J After funer	ertification;	27. Manner of Death 1 SNatural 5 □ Pending (Month, Day Year) 28b. Tin		28d. Describe how i	njury occurred	
DIVISION	death death ctor:	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm		28f Location (Stree	t and Number or Rui	al Route Number
2	s after s after of Dire	Certi	4 Homicide determined building, etc. (Specify)	, ottoot, raddry, onto	City or Town, S		
	To the Hospital or Attending Phyalcien: The law within 24 hours after death.  To the Funeral Director: After this certificate has a completely filled in by the funeral director, page 2 seminary.	edicai	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	leath occurred at the time, date and place or investigation, in my opinion, death occu	e, and due to the caus urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	Day, Year)
			I Liasynang om mis	RESOOD	A	pril.01,	2006
	3		30. Name and address of person who completed cause of death (Item 23a) (Ty	/pe, Print)			
				ANOVER ST. BA	ALTIMOR	E, MAR	(LAND
	Sta Registr		31. Date filed (Month, Day, Year)  APR 9 5 32. Registrar Signature	H Specific			

		1 - For State Registrar	State of W	aryland / Dep <i>Ce</i>	ertificate of		-	Reg. No.	16	0454
		1. Decedent's Name (First, Middle, Last					2. Date of De	ath	V	3. Time of Death
Physicia /Medic			Ronald	Wayne Hoh	cein		March	Day 28	Year 2006	3:45 P.M
Examin		4a. Facility Name (If not institution, give		)		r Location of Dear	th	4c. Count	y of Death	
		Joseph Richey H			Balti			N	V/A	
Funeral Director		5. Social Security Number 6. Se 218 44 3959	X 7. A	ge (In yrs. last birthda) 58 Yrs.	Months Days	If Under 24 Hrs Hours Min	(Month, Da	th y, Year) , 1947	Coun	lace <i>(State or Foreigi</i> try) yland
pug *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or I	ocation				1.	0d. Inside City Limits
within /2 hours atter death with the Maryland ene.  Hen "natural", or Items 23a or 28a-f show the Modical Examinat must be notified at	ē	Maryland N/A		Baltin					Ι.	1 ŽÝYes 2 □ No
28a	Director	10e. Street and Number		Dartin	10f. Zip Code			10g. Citizen of	What Coun	try?
3a of		820 N. Eutaw S	treet			201		U.S		-,-
ms 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S. 13	. Was Decedent of H		Specify Yes or No		ce - Americ	
I Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 反 Divorced	1 Yes 2□	No Viet Nam	1 ☐ Yes 2 ☐ No	Specify:	no Hican, etc.)		ock, White, by: Whit	
atura	ted	15. Decedent's Edu	ucation	16a. Dec	edent's Usual Occup	ation		16b. Kind of B	Business/Ind	fustry
9 S	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or	5+) life.	e kind of work done of DO NOT use retired	during most of wo d)	orking			·
Hygiene. sther ther ent, the N	Con	8th		Hane	lyman			Autor	nobil $\epsilon$	Repair
d oth	Be (	17. Father's Name (First, Middle, Last)		TT 1			me (First, Middle,		,	
Ment Barkec	ဥ			Hohrein,			rie Evel			
raum		19a. Informant's Name/Relationship (7)			ling Address (Street a Benzinger		ural Route Numbe Baltimo:			-
f Health Item 27 other tr		Sharon Geni / sis	erer	20b. Place of Disp		Noau	Date			
nt of 1 :: # Ita		1 ☐ Burial 2 🖸 Cremation 3 ☐ F		cemetery, cri	ematory or other place Crematory	a) 3/30	/2006	Baltimo		aryland
Important: if I any Injury or o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens								•
Department of Important: If It any Injury or one		Va. M.	1 - 24 - 1 00		22. Name and Addres					, r.A. and 21225
		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o	lications that cause	d the death. Do not e	ter the mode of dvin	g-such as cardia	c or respiratory a	rrest	riai y i	Approximate
te has been signed by the attending physicien and angle 2 should be detached for use as the burial-transit and and a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second seco	dical Examiner	Securifially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):						
0 0	Φ -	IF FEMALE:	23c. If yes, outcome	of prognancy					_	
by the attending tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				ate of delive onth	ry Day Year
	by P	Part II. Other significant conditions con	ntributing to death b	out not resulting in the	underlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to th	e cause of death?
should	ted						10	Yes 2□No	3 Proba	ably 4 Unknown
97 01	ompleted						24a. Was	an 24b.	Were autop	sy findings available
page	S						perfo 1 ☐ Yes	rm ed?	death?	
€ 5	Be	25. Was case referred to medical examiner?	laa-Nal.				ath Check only o	ne)		16.
p d	ဥ	1 Yes 2 No	lospital: 1 ☐ Inpation			4   Nursing r	lome 5 ☐ Resid		ner (Specify	Mospice
After	ē	1 Natural 5 Pending	(Month, Da	y Year) 28b. Time Injury	Work		28d. Describe I	now injury occus	red	
ctor: A	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Ini	ury - At home, farm, s		Yes 2 □ No	28f Location /5	Street and Numi	her or Rural	Pouto Number
Dir	ert	4 Homicide determined	building, et	c. (Specify)	rest, factory, office		City or Tov	vn, State)	our or regian	riodie ivarriber,
Funer ely fill	Medicai C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best ner: On the basis o and manner st	of my knowledge, dea f examination and/or i	th occurred at the time	ne, date and place pinion, death occu	e, and due to the	cause(s) and m date and place,	anner as sta and due to	ated. the cause(s)
within 2 To the I complet	Me .	29b. Signature and title of certifier	/	ıA -	29c. License			29d. Date signe	ed (Month, L	Day, Year)
- H O		11/1/25	\ /	(V,V)	1		1	_		
		/ V ment 1	LMS	עניו.	1)(	96031	9	/V\2	- ~ 0	200
1/x,		30. Name and address of person who co	ompleted cause of o	leath (Item 23a) (Type		06031	9	11/2/4	128	2006
14		30. Name and address of person who co	. 0	death (Item 23a) (Type		ocoisi Bultim	re Mn	M240	130	3

			For State Registrar	State of Ma	ryland /	•	ent of H		Mental Hy	giene	05	0455
	- · · ·		Decedent's Name (First, Middle, Last)						2. Date of De		Year	3. Time of Death
	Physicia /Medic			Rita	D. Hov				3	29	2006	ZZZ8 M
	Examin	er	4a. Facility Name (If not institution, give s	07	01-	12	01-	Location of Death	1	4c. Cour	nty of Death	
7			5. Social Security Number 6. Sex	lot So	(In yrs. last b	-	nder 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birthi	place (State or Foreign
Howall	Funeral Director			M 2₫F	54	Yrs. Mor	iths Days	Hours Min.	(Month, D.	ay, Year) -1951	Coui	Md
ತಿ 🗖			Usuel Residence of Decedent									
	arylar show	_	10a. State 10b. County N/A		10c. City, Tov	wn or Location	1				,	10d. Inside City Limits  XXYes 2 □ No
单	the Maryland r 28a-f show	ecto					( 7: 0-4-			10- 09	-4 \A(b = 4 C=	
4.21	with the sor 2	ä	10e. Street and Number 3909 Penhurst Aven	11.6		10	f. Zip Code 2121	5		10g. Citizen o		ntry :
Ľ	ier death with the Maryland Hems 23s or 28a-1 show iner must be notified at	Funeral Director		2. Was Decedent E	Ever in U.S.	13. Was [		ispanic Origin? (S In, Mexican, Puert	pecify Yes or N		Race - Ameri	can Indian,
ía (O		FE	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ N	lo	1	specify Cuba es 2 No		o Rican, etc.)		llack, White, c <i>ify:</i> B1ac	
33		l by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		104	es 2ENO	Specify:		Spe	cify: DIA	CK
5-0	72 Inal	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	168	a. Decedent's (Give kind o	Usual Occup	ation during most of wor f)	king	16b. Kind of	Business/In	ndustry N/A
ر ا	d within 72 piene. r then "net	ш	Elementary/Secondary (0-12)	College (1-4or 5 2 years	+)		abled	1)				N/A
مي ط 212		e Co	12th grade  17. Father's Name (First, Middle, Last)	2 years			abied	18. Mother's Nan	ne (First, Middle	e, Maiden Sum	ame)	
an	9 E 5 S	To Be	Joseph Howell					Mab1e	Herbe	ort		
Maryland 21215-0036	should be filed and Mental Hygi marked other umatic event, I	H	19a. Informant's Name/Relationship (Typ	oe, Print)	19	b. Mailing Ad	iress (Street	and Number or Ru			vn, State, Zip	o Code)
	ss 1 and 2 should by Health and Ment item 27 is marked rother traumatic e		Mable Howell - Mo	ther		524 N.	Char1	es Stree	t Apt 10	09 Ba	1to, 1	Md 21201
patha altimore,	of He of He fitem	1/3	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	amoual from State	20b. Place cemet	of Disposition ery, crematory	(Name of or other place		Date	20c. Locatio	,	
patra altimore	Page nent o ant: If ury or		4 Donation 5 Other (Specify)	enioval nom State	Mt Z	ion Ce	metery		-2006	200	own, l	Md
at a	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service License	1)/	DOM)	22. Nan	ne and Addre	ss of Facility	March F	/H Wes	t	
ω_	20E = 0		1 noma	· onor				0 Wabash			, Md 2	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	e cause on each lin	the death. Do	not enter the	mode of dyin	ig, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		25 12		w+	ta:lu	50			Iday
	Examiner			61	consequence		1000	+ 0:	3 \	_	_	710
4		e	Sequentially list conditions, if any, leading to immediate		a consequence		. Mea	5-1 00	36020	1		10 years
9	e be executed sician and e burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	dia	batas	s m	alth	LS.			7	2-204 CIS
ó	an an rriai-tr	Exa	resulting in death) Last	Due to (or as	a consequence	e of):						,
8760,	cate be executed physician and the buriaf-transli	dicai										
9	ertifica ling pl	0	IF FEMALE:					<u></u>				
Вох	eath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1⊟Live birth	2 Fetal deat		pic pregnancy	,			Date of deliv Month	rery Day Year
o.	he de the s	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 LI Othi	er (specify)					
مَ	that the	/ Ph	Part II. Other significant conditions con	tributing to death be	ut not resulting	in the underly	ing cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to t	the cause of death?
Sp	8 50	d by							1 🗆	Yes 2 □ No	3 Pro	bably 4 Nhknown
2	w requires been si	Completed							24a. Wa	s an 24	b. Were auto	opsy findings available ompletion of cause of
æ	The lav	mo du							auto peri 1 ☐ Yes	formed?	prior to co death? 1 ☐ Yes	
ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of Dea				
>	Physicia this cert al direct	To E	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 🗌 Inpatie	nt 25 ER/C	Outpatient 3	DOA Oth	er: 4 🗆 Nursing H	lome 5□Res	sidence 6 🗆	Other (Speci	fy)
<u>_</u>	ding Ph h. After th funeral	ë	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	y Year) 28b.	. Time of Injury	28c. Injur Wor		28d. Describe	how injury occ	curred	
sio	Attendi death. ctor: A y the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	20 - Pt(1-i		N		Yes 2 □No	29f Leasting	/Street and No	mhar or Due	ral Route Number,
Division of Vital Records, P.O.	or All after of Direction by	Certification;	4 Homicide determined	28e. Place of Inju- building, etc	c. (Specify)	tarm, street, t	actory, office			own, State)	iniber of Aur	ar Houte Number,
	spital hours ineral y filled		29a. Certifier Certifying Phys									
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai	(Check only 2 Medical Examile one)	and manner sta	examination a ated.	and/or investig	ation, in my o	pirion, death occi	med at the time	, vale and plac	and due t	One Cause(S)
	To To con	2	29b. Signature and title of certifier	. 🖚			29C. Licens	e number		29d. Date sig	mea (Month,	, Day, Year)
	5		70	MD			D> 9	3165 2	+	2/30	ص اد	~ b
	9		30. Name and address of person who co	mpleted cause of d	eath (Item 23a	i) (Type, Print)	no: 1	loso to	e F	Bal	time	012
	Sta	ite	31. Date filed (Month, Day, Year)	322 Registra	ar's Signature	don't	1)	e number 31652 losp. ta				-
	Regist		APR 0 5 200	6 De Busin	a St.	A. T. Wall						

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Physicia /Medic		Thomas Halton Hale, Jr.		01 2006	8:30PM
Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c County of Death	
	×6	Franklin Square Hospital Center Rosedale 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.   Minnites   Days   Hours   Min	8. Date of Birth		place (State or Foreign
Funeral Director	İ	217-07-9111 1X M 2□ F 89 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 5,	1917 OKL	place (State or Foreign intry) Ahoma
D D		Usual Residence of Decedent			
arytar ehow	7	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
the M	Director	Maryland Baltimore Nottingham  10e. Street and Number 10f. Zip Code	10g	Citizen of What Cou	
death with the Maryland ms 23a or 28a-f ehow rmust be notified at		4 Scone Garth 21236		U.S.A.	,
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Anned Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri Black, White	
0036 hours after ural; or ite	y Fu	1 Never Married 2 Marned 1 Never Married 2 Marned 1 Never Married 2 Marned 1 Never Married 2 Marned 1 Never Married 2 No Specify:	or mount, over,		rite
hours	ed by	3 X Widowed 4 □ Divorced Year or Dates: ₩₩ 11  15. Decedent's Education 16a. Decedent's Usual Occupation	168	o. Kind of Business/Ir	
215 215 21 22 22 23 24 25 25 25 25 25 25 25 25 25 25 25 25 25	piet	(Specify only highest grade completed)  [Give kind of work done during most of work file. DO NOT use retired]  [Elementary/Secondary (0-12)   College (1-4or 5+)	king	elf-Employ	
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be tile	Be	17. Father's Name (First, Middle, Last)  Thomas Halton Hale, Sr.  18. Mother's Nam  Bern	ne (First, Middle, Mai	<sub>den Sumame)</sub> apleton	
Maryland 21215-0036 Maryland 21215-0036 the and Mental Hylgene, in the and Mental Hylgene, zz la marked other than "netural", or traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event, the Medical Example traumatic event event, the Medical Example traumatic event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event event ev	ပ္	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		<u> </u>	in Code)
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		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	or respiratory arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)  Due to (or as a consequence of):			
Examiner		Hypovania			
\ <b>D</b> =	ner	if any, leading to immediate  Due to (or as a consequence of):			
60, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
cords, P.O. Box 68760, wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriat-transit	caiE				
687 ifficate g phys		d			
Box 68 sath certifica	M/UE	IF FEMALE: 23b. Was decedent pregnant 1		23d. Date of deliv	•
e deat the att	Physician/Med	in the past 12 months?  1		Month	Day Year
P.O. that the de by the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68 to attending Physician: The law requires that the death certifica after death.  Director: After this certificate has been signed by the attending phy in by the tuneral director. page 2 should be detached for use as the fin by the tuneral director.	d by	Atrial Fibrillation	<b>N</b> Yes	2 No 3 Pro	bably 4 Unknown
COT IW red	Completed		24a. Was an	24b. Were auf	topsy findings available
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of Vital Physician: this certifica	ည	1 Yes 20 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	forme 5 Residence		uty)
On (ding Fh.	tion	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	20d. Describe now	india occurred	
Vision Atten	ifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rus	ral Route Number,
Div	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City of Youri, S	nate)	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place	e, and due to the caus	e(s) and manner as and place, and due	stated. to the cause(s)
thin 24	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month	n, Day, Year)
D 1 3 1 0 0	_		Λ	Pril A	2006
. 1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	O = D	1111 01	acce
1071		DR. Navara Centola 9000 Franklin Square Drive	, Baltim	ore, MD.	21337
Sta Registr		31. Date filed (Month, Day, Year)  APR 0 5 2006  32. Pegistrar's Signature.		•	
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and w	-	Jsuaf Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Loca	ation						1	0d, Inside City Limits
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23a o	<u>a</u>	7700 Cherry Lane				2	0707			Ţ	J.S.A.		
ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene.  If Itam 27 is marked other than "natural", or itams 23a or 28a-1 ahow or other traumatic avent, the Medical Examinat must be notified at To Re Completed by Financial Director.	y runer	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 A If Yes, Give Year or Dates:	ver in U.S.	If '	/as Deced Yes, spec	rfy Cubar	panic Origin? (S , Mexican, Puer Specify:	Specify Yes to Rican, e	or No- tc.)	14 Race Black, Specify:	White,	
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/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):								
	20	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i onnaedrauca	of).							-	
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that the death certification bed by the attending of detached for use as	ysician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pro Other (sp		<u>.</u>			23d. Date Mont		ny Day Year
		Part II. Other significant conditions co Seizure Disorder	ntributing to death bu	it not resulting i	n the uno	derlying ca	ause give	n in Part I.	236	Did tobaco			e cause of death?
or Attending Physician: The law requires t after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be entitle after the completed by	Completed by	Gastritis						· · · · · · ·	24a	. Was an autopsy	Dri	ere autopor to cor ath?	psy findings available appletion of cause of
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15		30. Name and address of person who ca R.G. Bhojraj, M.D	. 704 Goi	rman Ave			l Lā	urel, M	Maryla	nd 2	0707		
State Registrar		31. Date filed (Month, Day, Year) APR 0 5 2	32. Pagistra	r's Signature	Lo	and of	,						

			1- State of Marylan Registrar	-	rtment of Heatificate of De			21116	10459
	25		Decedent's Name (First, Middle, Last)		unoate of D		2. Date of Death	g. No:	3. Time of Death
	Physici /Medio		Mary E. HICKS				March	26 206	06:48
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Lo		VICT	4c. County of Death	
			Johns Hopkins Bayview		Baltimo	re		N A	1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I	**		f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birth	place (State or Foreign
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	1 and 1 Health em 27		THERESA HICKS (DAUGHTER) 20a. Method of Disposition 20b. P		FLOWERTON Sition (Name of			D 21229 0c. Location - City or T	oum State
Baltimore,	Pages nent of ant: if it		1 🗷 Burial 2 □ Cremation 3 □ Removal from State	emetery, crem	natory or other place)	_			own, State
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14	p ts	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ience of):					1-2
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ŏ	at the death certific by the attending patached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d. Date of deliv	rery
œ.	death	icia	in the past 12 months?  1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2 ☐ Y		Ectopic pregnancy Other (specify)			Month	Day Year
P.O. Box	The law requires that the site has been signed by the sage 2 should be detached.	hys	9 □Unknown 9□Unknown						
	signed d be det		Part fl. Other significant conditions contributing to death but not resu	Iting in the un	derlying cause given i	in Part I.		icco use contribute to	
ord	w requir been si should I	ted					1 L Yes	2 No 3 Pro	bably 4 @Unknown
Sec.	e law has b	Completed					24a. Was an autopsy	24b. Were auto prior to co	opsy findings available ompletion of cause of
Division of Vital Records,							performe 1 Yes 2	ed? death? No 1 ☐ Yes	2□ No
Ĭ	ysician: iis certifica director,	o Be	25. Was case referred to medical examiner?  1   Yes 2   No		Othor	6. Place of Death			
ō	Attending Physician: r death. sctor: After this certifically the funeral director.	J: To	27. Manner of Death 28a. Date of fnjury	ER/Outpatient 28b. Time of	3□ DOA 28c. Injury at Work?	4   Nulsing Hon	e 5 ☐ Residen	ce 6 Other (Speci	<i>fy)</i>
<u></u>	ath. r: Afte e fun	atlo	1 12 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		s 2□No			
<u> </u>	or Attendation destriction of Director: in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office	2	8f. Location (Stre	et and Number or Rur	al Route Number,
ō	tal or A	Cer	building, etc. (Specify	<i>'</i>			Oily of TOWN,	Siale)	
	Hospital	ledicai	29a. Certifier 1 ✓ Certifying Physician: To the best of my know (Check only one) 2 ☐ Medical Examiner: On the basis of examinat	vledge, death	occurred at the time,	date and place, a	nd due to the cau	ise(s) and manner as s	stated,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Med	one) and manner stated.  29b. Signature and title of certifier		29c. License nu				
	T × S		PON MARITO ADICA -			_ ~~		d. Date signed (Month,	
			30. Name and address of person who completed gause of death (Item	23a) (Tuno 1	PES	- 000	M	arch 28	2006
	17		Anne TVS KeV	_oa) (+ <b>y</b> pe, F		Easter	) ALIPA	Je 2122	24
	Sta	te	31. Date filed (Manth, Qay, Year) 32 Registrar's Signat		1.1-10	20101011	. 110011		
۲ .	Registr	ar	APR \$ 5 2006	1500					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10460 State
Registrar Amend #1 Per Phy G855 5/03/06 entificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 04-03. 4:15 PM 2006 BEMPICE HARRINGTON Beatrice Herrington 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Neme (If not institution, give street and number) BALTIMORE HOSPICE TOWSON GILCHRIST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 C 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 101 F Yrs 03.02. 217.52.8589 اما Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10h Counts 1 ☑ Yes 2 ☐ No NIA BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1306 W. LEXINGTON STREET 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 18 Never Married 2 Married 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) HOSPITAL HOUSE KEEPING NA 18. Mother's Name (First, Middle, Maiden Surname)

Elementary/Secondary (0-12) 11 TH GRADE 17. Father's Name (First, Middle, Last) LED HARRINGTON BEATRICE WELDON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

(DAUGHTER) 867 W. LEKINGTON ST. BALTO. MD ce of Disposition (Name of Date 20c. Location RHONDA TAYLOR 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 04-10-06 BALTO, MD MOIX - TM 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureign Service Licensee 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE

5151 BAUTO, NATE PIKE, BAUTO, MO 21229 angon 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Physician

/Medical

Examiner

10a, State

MD

**Funeral** 

Director

r than "naturel", or Iteme 23s or 28s-1 show the Medical Examinar must be notified at

Maryland 21215-0036

Baltimore,

P.O. Box 68760.

Records,

Division of Vital

errington,

iit. Pages 1 and 2 should be fili artment of Heelth and Mental Hi ortant: If ttem 27 le markad oth

0

Physician /Medical

Examiner

attending physicien and for use as the burial-transit

ate hes been signed by the page 2 should be detached

Physician/Medical

۵

Completed

Certification: To

Medical

Direct

Funeral

δ

Completed

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

0 6 on CANCER Due to (or as a consequence of)

Due to (or as a consequence of):

Due to (or as a consequence of)

23b. Was decedent pregnant

in the past 12 months? 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death 9☐ Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

Year Day

Approximate Interval Between Onset and Death

ears

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Struke

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 Natural 2 Accident 5 Pending investigation 6 ☐ Could not be 3 Suicide

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2120%

29a. Certifier

4 / Homicide

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier mother

und

29d. Date signed (Month, Day, Year) pril 4, 2006

person who completed cause of death (Item 23a) (Type, Print) N. Charles St. BIMC 6701

Hospital:

State Registrar 31. Date filed (Month, Day, Year) APR 9 5 2006 2. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

within 24 hours a

To the Funeral C

completely filled i

			4	artment of Health and Ment	tal Hygien	2000 10401
	Physici /Medio		1. Decedent's Name (First, Middle, Last)  John H. Hughes Sr	- N	burch 2	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
F	Examir	ner	4a. Facility Name (If not institution, give street and number)  Sacre D Heart	4b. City, Town, or Location of Death  CUMBERLAND		c. County of Death ALLEGANY
	Funeral Director		5. Social Security Number  215-34-4280  Contact Sex 1	If Under 1 Year   If Under 24 Hrs.   8. D   Months   Days   Hours   Min.   F e	ate of Birth Month, Day, Yea b 1, 19	9. Birthplace (State or Foreign Country) 35 Maryland
	Maryland I-f ehow	tor	10a. State         10b. County         10c. City, Town or L           MD         Allegany         Frostbut			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23s or 28s	al Director	10e. Street and Number 10409 Borden Road NW	10f. Zip Code 21532	10g. C	itizen of What Country?
036	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. do ther than "naturel", or items 23a or 28a-f ehow do ther than "naturel", or items 23a or 28a-f ehow event, I'm Madical Examinat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Married 12. Was Decedent Ever in U.S. Amed Forces?  1 Never Married 2 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 Never New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New 1 New	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican I ☐ Yes 2 ¼ No Specify:	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc. Specify: white
21215-0036	filed within 72 ho Hygiene. other than "natur ent, the Medice.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of working DO NOT use retired) Oofer		Kind of Business/Industry  me improvements
73	should be filed and Mental Hygi marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Frederick Francis Hughes	18. Mother's Name (Firs	st, Middle, Maide	n Sumame)
	and 2 ealth a m 27 le		Judy A. Hughes/spouse 1040	ing Address (Street and Number or Rural Rounds)  9 Borden Road NW Frost	stburg,	MD 21532
Baltimore,	Pege nent ant: H ary o		4 Donation 5 Other (Specify)	matory or other place)		Location - City or Town, State
ea Pa	permit. Departr Importa			2 Name and Address of Facility tate Anatomy Board 65 altimore, MD 21201		
	Physician /Medical		shock or heart failure. List only one cause on each line.		•	Approximate Interval Between Onset and Death I Leann
8/60,	end I-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ocadial Inforti		yems
O. Box 6	that the death certificate be en ed by the attending physicien detached for use as the buria	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the u		23e. Did tobacco	use contribute to the cause of death?
II Kecords,		Completed	Myselv dy s plastic Synds		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
ion of Vital	To the Hospitel or Attending Physician: with 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director,	To Be	25. Was case referred medical examiner?  1 Yes Anoner of Death Anoner of Death Another Service (Month, Day Year)  27. Manner of Death Another Service (Month, Day Year)  28b. Time of Injury  28b. Time of Injury			
DIVISION	tel or Atters after de al Directo	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specity)	reet, factory, office 28f. L. C	ocation (Street a lity or Town, Sta	nd Number or Rural Route Number, te)
	the Hospi nin 24 hou the Funer npletely fill	fedical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurred at	the time, date ar	nd place, and due to the cause(s)
)	To To	Z	29b. Signature and title of certifier	29c. License number  D 2 1 2 4 4		ate signed (Month, Day, Year)  3/29/2006
			30. Name and address of person who completed cause of death (Item 23a) (Type, DR. Jesus Tow H Broadway Fr 31. Date filed (Month, Day, Year) 32. Registrar's Signature	OSTBURG, MD	21532	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 5 2006			

CPM 06-02265 Gladys Henderson Amend unpend item#17,23a,27, perth, Mr. 6324, 4/12/16 TT

State of Maryland / Department of Health and Mental Hygiene For Stete Registre 1-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month ŎĨ, 2006 Gladys Marita Henderson April 19:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1350 North Stricker Street Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12–21–1949 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Mary land 216-52-0539 56 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r then "naturel", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 □ No NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1350 N. Stricker Street 21217 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ρ 3 Widowed 4 Divorced Black. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen. Important: If Item 27 Is marked other the eny injury or other traumatic event, Inbi. 2010. Welder. Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Oscar Henderson Gladys Banks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Burke/ Mother 1352 N. Stricker Street Baltimore, MD21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 04-10-06 Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility unerla Gones Wylie Funeral Home 638 N. Gilmor Street Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical the IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 \( \sqrt{N}\) certificate 1 Yes 25. Was case referred to medical examiner?
1.⚠ Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) this P 1 Inpatient 2 ER/Outpatient 3 DOA : After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No I Director: 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter or To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Admedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and O.C.M.E. April 02, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

APR 0

5 2006

		•	For State Registrar	State of Mary	-	rtment of H			iene 19. No. 0 0 6	10463
	18		Decedent's Name (First, Middle, Last)	·				2. Date of Death	h Day Year	3. Time of Death
	Physicia /Medic		John Howard Hall					March 30		10:10p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give stre	eet and number)		4b. City, Town, or	r Location of Death		4c. County of Death	
			Joseph Richey Hospi			Baltimor			N/A	
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
	Director		21/-28-2544	74	Yrs.			May 25,	1931 Mary	zland
	and with		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Manyl	ò	Maryland Baltimore	Ha	alethorpe					1 ☐ Yes 2 ☐ No
	with the Maryland a or 28e-f ehow	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Cou	intry?
	ith with the Marylar 23a or 28e-f ehow		4600 Lincoln Drive			21227			USA	
	death	Funeral		. Was Decedent Eve	r in U.S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
(0	or Ite		1 Never Married 2 Married	Armed Forces? 1√PYes 2 No F If Yes, Give			Specify:	o mican, etc.)	Black, White	
Ğ	rel', c	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		I□Yes 2√√2 No	эрөспу.		Specify: Wh	nite
5-0	within 72 hours after ene. then "naturel", or ite ne Medical Exemine	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	(Give	lent's Usual Occup kind of work done	during most of work	king	16b. Kind of Business/li	ndustry
21	tthin or	du	Elementary/Secondary (0-12)	College (1-4or 5+)		OO NOT use retired	,			
2	be filed withintal Hygiene. Ind other then		47 Fabrus North Clima Middle Local	4	Emerge	ncy Manac		ne (First, Middle, M	FEMA	
and	be fill	Be	17. Father's Name <i>(First, Middle, Last)</i> Howard Hall				Margaret		and an annual state of	
ž	2 should be and Mental is marked c aumatic eve	ို	19a. Informant's Name/Relationship (Type	Print)	19h Mailin	a Address (Street			, City or Town, State, Zi	ip Code)
7 Maryland 21215-0036		-	Marian Hall- wife	, , , , , , , , , , , , , , , , , , , ,	1	•			, MD 21227	
affmore,	# O - L		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Rer	noval from State	-	natory or other plac	1		20c. Location - City or T	own, State
Olf E	artmenlactronic Page ortant:		4 □Donation 5 □Other (Specify)  21. Signature of Fune al Service Licensee		Meadowridge	Memorial F		2006 E	lkridge, M	)
Bal	permit. Page Department of Important: If eny Injury or once.		21. Signature of Furthal Service Licensee					eral Hom	e at MMP, 1 idge, MD 21	INC.
			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the	death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arri	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Marken	LIN	EDA AS	m 05	130	APAI	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a co			(70)		1100	1100143
	Examine	-	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
A	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.							
Do.	be executed icien and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
976	e y e	dicai	d.							
× 62	entific ding p	/Me	IF FEMALE: 230	c. If yes, outcome of p	oregnancy				23d. Date of deli	wan.
Bo	attend for us	ian	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at tim	Fetal death 3	Ectopic pregnancy Other (specify)	1		Month	Day Year
Mo	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	0 0 0000	3 01101 (30001)7 _				
ď	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as the	by Physician/Med	Part II. Other significant conditions contr	ibuting to death but n	ot resulting in the u	nderlying cause giv	en in Part I.		bacco use contribute to	
cords	w require been si should I	Completed							es 2 No 3 Pro	
33	elaw hasb	mple						24a. Was a autops perform	by prior to c	topsy findings available completion of cause of
2 E	: The							1 ☐ Yes	2X No 1 ☐ Yes	2□ No
1	ilcian: The lav certificate has rector, page 2	Be	25. Was case referred to medical examiner?	spital:		-C Ott	ner	ath (Check only on		Hospe
<b>5</b>	fing Physician: 1. After this certifici	. To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury	2 ER/Outpatier	II 3 DUA	4   Nursing H	lome 5 Reside	ence 6 ther (Spec ow injury occurred	(ity) ( 6>1/CE
2 5	ending eath. or: After	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yo	ear) Injury		rk? ]Yes 2∐No			
isi	l or Attendi after death. Director: A	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury building, etc. (	- At home, farm, str	reet, factory, office			treet and Number or Ru	ral Route Number,
10g	afor A after Direct of in by	Certification:	4  Homicide determined	building, etc. (	Specity)			City or Town	n, State)	
( )	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of ner: On the basis of ex	amination and/or in	h occurred at the till vestigation, in my	me, date and place opinion, death occu	a, and due to the curred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
-	To the within 2 To the comple	Mec	29b. Signature and title of certifier	1	)	29c. Licens	se number	2	29d. Date signed (Month	ı, Day, Year)
	V 1	1	(llarce of	Mrs.	wh	Doc	>58217	2 (	03/31/06	
	700		30. Name and address of person who con	pleted cause of deat	h (Item 23a) (Type,	Print	16	7,	NOT W	12 7 17 19
	+		MARCEL #31. Date filed (Month, Day, Year)	32. Registrar's	Signature	BOLTE	5026	(AT)	MOKE, PL	02/2/7
	Sta Registi		APR 0 5 2006	And And	A Ago	wer .				

			. For	State of Maryland			f Health a		•	•	,	
			1 - State Registrar		Cer	tificate c	of Death		Re	g. No.	Jb	UHDH
П	Physicia	an	1. Decedent's Name (First, Middle, Last)						Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Dashawn Dav			4b. City Tour	n, or Location o		larch_		2006 hty of Death	3:30p <sup>M</sup>
	Examin	er	Johns Hopkins		-	,,	altimo:			40. 0001	n/a	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye Months Day	ar If Under 2		Date of Birth (Month, Day,	Vearl		ace (State or Foreign
	Director		n/a	M 2□F 0	Yrs.	IVIOTITIS Da	1	IVIII).	3/25/	06	Mar	ÿland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Lo	cation					10	Od. Inside City Limits
	Mary	tor	Md n	/a	Ва	1timor	e					1 XYes 2 ☐ No
	ith the	Oirec	10e. Street and Number			10f. Zip Cod			10	_	of What Coun	try?
	s 23e	by Funeral Director	3820 Mt. Pleas		1401		1224	-1-0 (016	V-1		USA ace - Americ	- ( - 1
	fter de ritem frer	Fune	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No			of Hispanic Orig Juban, Mexican	, Puerto Rica	an, etc.)		lack, White,	
93	ral, o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	1 □ Yes 2129!	No Specify:			Spec	B B	lack
5	filed within 72 hours after death with the Maryland Hygiene. sther then "natural; or items 23e or 28e-f ehow ent, the Medical Exam er must be notified al	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	ient's Usual Oc kind of work do DO NOT use re	ne durina most	of working	1	6b. Kind of	Business/Ind	lustry
12	withir ene. then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)	me. L	n/a	•				n/a	
פ	be filed within 72 hours after death with the Marylan at all tyglene.  I al Hyglene.  I other then "natural", or Items 23e or 28e-1 show other then "natural" or Items and other then "need of the then "need or Items at a second of the then "need or Items".	Be C	17. Father's Name (First, Middle, Last)				7		irst, Middle, M			<del>- 1</del>
<u>Var</u>		To E	unknown					Dash	a Hen	ley		
Jan	12 sho		19a. Informant's Name/Relationship (Ty	oe, Print)		_	eet and Numbe			-		Code) 21224
(a)	s 1 and 2 should if Health and Men Item 27 is marke other traumetic		Barbara Bennett  20a. Method of Disposition	20b. Pla		sition (Name of natory or other)		Date			n - City or To	
و ا	Pages nent of int: If it ury or o		1 ☐ Burial 2 【ACremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)				etory (	4/4/0	)6	Balt:	imore	. Md.
Baltimore, Maryland 21215-0036	permit. Pages 1 Department of H Important: If Ite any injury or ott once.		21. Signature of Funeral Service License				dress of Facility					,
<u> </u>	89 E 8 8		Tolar		1	201 Du	ındalk	Ave.	Balt	imor	e, Md	
l,			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. ne cause on each line.	Do not ente	er the mode of	dying, such as o	cardiac or re	spiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Extreme Pro		rity						
	Examiner		[ ]	Advanced Co		al Dil	lation					
	g #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Die to (or as a conseque	enne of/r							
_	xecute and Il-trans	Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ence of);							
760,	ate be executed hysicien and the burial-transit	calE		l								
89	rtificat ng ph) as th		IF FEMALE:									
Вох	death certifica e attending ph d for use as th	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal	death 3	Ectopic pregna					Date of delive Month	ry Day Year
o.		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown	atn 5	Other (specify	)					
٥.	The law requires that the ste has been signed by the bage 2 should be detache	by Ph	Part II. Other significant conditions cor	ntributing to death but not resul	ting in the ur	ndertying cause	given in Part I.		23e. Did tob	acco use co	ontribute to th	e cause of death?
ğ	v require been sig should b					<u> </u>			1 🗋 Ye	s 25ANo	3 🗌 Prob	ably 4 Dunknown
Records,	The law r cate has be page 2 sh	Completed							24a. Was ar autopsy perform	/	prior to con death?	osy findings available npletion of cause of
			OF Man ages referred to medical					1.5 -1- (2	1 ☐ Yes 2	No No		2 No
<u>=</u>	Physiclen: r this certificated director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	lospital: 1 🔀 Inpatient 2 🗆 E	R/Outpatien	t 3 DOA	Other: 4 Nu		theck only one 5 ☐ Reside		other (Specify	·)
	E e	T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending		28b. Time of Injury	28c. li	njury at Work?		l. Describe ho			,
Sio	Attending or death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be	Co. Plan of trium. At how			1 ☐ Yes 2 ☐ N		Location (Ctr	rood and Abra	There or Our	I Pauta Number
Σ	l or Al after o Direc J in by	Certification:	4 Homicide determined	28e. Place of Injury · At hor building, etc. (Specify)	ne, rarm, str	еет, тастогу, опі	Ce	201.	City or Town		noer or Hura	l Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu		29a. Certifier 1 SC Certifying Phys	sician: To the best of my know ner: On the basis of examinati	/ledge, death	occurred at th	e time, date and	d place, and	due to the ca	use(s) and r	manner as st	ated.
	the H hin 24 the F mplete	Medical	one)  29b. Signature and tittle of certifier	and manner stated.			ense number				ned (Month, i	
	J. W. T. O.	-	290. Signature and the of continue	MY	>		58980			_	25,	
			30. Name and address of person who co			Print)						2000
				940 Eastern		Balt	imore,	Mary	yland	. 212	24	
	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 5 2006	32 Registrar's Signatu		Letter .						
	3		רו מי מי נינו	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	-							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2006 Month **Physician** March 30, HACKETT SARAH LEGARE SMITH 10:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Glen Arm
If Under 1 Year If Under 24 Hrs. GLEN MEADOWS HEALTHCARE CENTER Baltimore County 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕁 F 88 Director <u> 215-09-2473</u> Mar 12, 1918 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 ☐ Yes 2 🕅 No Directo Maryland Baltimore County Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road 21057 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene.
other than "natural", or item 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Trade Editor Journal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: if item 27 is marked of Be Horace Taylor Smith Mabel Wolf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 119 Taplow Road, Baltimore, Maryland 21212 Mrs. Carolyn S. Cook (Niece) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o important: if eny injury or once. Green Mount Cemetery 4/3/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. Martin D. Lawson

6500 York Road, Baltimore, Maryland 21212

23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PHEUMONT 7 DAYL /Medical Due to (or as a consequence of): Examiner CANCER UNG MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine inding physicien end use as the burial-translt The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the e should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 □Unknown 1 Tyes 2 No Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No pege 2 1 Yes 2 No erei Director: After this certific filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 🖫 Gursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 17 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident hours after deat unerei Director: 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 51228 2006 JA: Flood KAMAN A AN 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ramana Gopalan, M.D. 2 East Rolling Cross Road, Catonsville, Maryland 21228
31. Date filed (Month, Day, Year) 32 Registrar's Signature State mande

DHMH 17 Rev 1/2001

Registrar

APR 0 5

		For State	e of Maryland /	Depa		ealth and	Mental Hyg	iene	04.66		
Toglotta					uncate of L	Jeani	2, Date of Deat	eg. No.	3. Time of Death		
Physic	ian	1. Decedent's Name (First, Middle, Last)					Month	Day Year			
/Med		John W. Iacobao						30, 2006	12:40 A M		
Exami	ner	4a. Facility Name (If not institution, give street an		-	4b. City, Town, or		ath	4c. County of De			
		Chesapeake Hospice H		hinth da . N	Anna If Under 1 Year	polis	rs. 8. Date of Birth	Anne An			
Funeral		1 <b>X</b> □ M 2□	1X□ M 2□ F Vrs			Months Days Hours Min. (Month			n, Day, Year) Country)		
Director		096-07-1618 Usual Residence of Decedent	90				April 1	, 1915	New York		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hyglene.  Deperment of Health and Mental Hyglene.  Important: If item 27 is marked other than "naturel", or items 23a or 28a-1 show any injury or other treumetic event. The Medical Examiner must be notified at once.	}	10a. State 10b. County	10c. City, To	own or Loc	cation				10d. Inside City Limits		
	to	Maryland Anne Arundel Annapolis						Y Yes 2 □ No			
tha ross	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?		
3a ou	0	1056 Eaglewood Road	214	03	United	States					
death ms 2	Funeral	11 Marital Status 12. Was			(Specify Yes or No- erto Rican, etc.)	14. Race - Am	erican Indian,				
after a	표	1 ☐ Never Married 2 ☐ Married 12 ☐ Yes 2 ☐ No					eπo Hican, etc.)		Black, White, etc.		
gers on s	by	3√∑ Widowed 4 □ Divorced If Yes, Give Year or Dates 1943-45			☐ Yes 2X☐ No	Specify:		Specify: White			
72 hc	Completed	15. Decedent's Education (Specify only highest grade comple	16 (16)	Sa. Deced	ent's Usual Occupa	ation during most of v	vorkina	16b. Kind of Busines	s/Industry		
thin thin	npidu		s Education t grade completed)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)								
ed w	S	10th	10th Owner						Textile Plant		
tal Hy	Be	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, I	Maiden Sumame)			
Men Men arke	ို	Anthony Iacobac				Man	-	Pasquale			
2 shg and ls m		19a. Informant's Name/Relationship (Type, Print	1					, City or Town, State,			
and and ealth m 27		Robert Iacobacci/ son				Road		, Maryland			
of H		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal		of Dispos tery, cren	sition (Name of natory or other place	θ)	Date	20c. Location - City o	r Town, State		
Pages ment of ant: If it		*4 □Donation 5 □Other (Specify)			del Crema			Odenton,			
permit. Pages Depertment of Important: If if any injury or o		21. Signature of Funeral Service Licensee		Dc	. Name and Addres onaldson	s of Facility Funeral	. Home & C	rematory,	P.A.		
7 70 2 2 9		Juanta Ox Homas		12	+11 Annap	OIIS KC	aa vaent	on, maryia	and 21113		
		23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
Physician		Immediate Cause (Final disease or condition End Stage COPD							Onset and Death Years		
/Medical		resulting in death)  Due to (or as a consequence of):									
Examiner		Sequentially list conditions, b.									
, p	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease of Figure 1) that initiated events c.									
acute and -tran	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
e be ex			e to (or as a consequent	Je 01).							
cate b	dicai	d				<del></del>					
artific ding p	Physician/Med	IF FEMALE: 230 If you	coutcome of pregnancy								
ath car	ian	23b. Was decedent pregnant in the past 12 months? 1						23d. Date of delivery  Month Day Year			
the s	ysic										
hat the	P							Did tobacco use contribute to the cause of death?			
signe Signe	i by							☐ Yes 2 ☐ No 3 🛱 Probably 4 ☐ Unknown			
VICAL INECOLOS, F.C. BOX 00 (00), siclen: The law requires that the death cartificate be exacuted certificate has been signed by the attending physicien and rector, page 2 should be detached for use as the burial-transit	Completed							-1			
e law	ld I						- autops	24a. Was an autopsy findings avails prior to completion of cause death?			
The the cate	S	1						☐ Yes 2X No 1 ☐ Yes 2X No			
STOLL OF MAIN tending Physicien: ` Beath. tor: After this certifica the funeral director, p	Be	25. Was case referred to medical examiner?  Hospital:			Othe		eath (Check only on				
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or A after Dirac	Certification:	4 Homicide determined	, iaiii, str				(Street and Number of Hural House Number, own, State)				
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To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Me	29b. Signature and title of certifier	1		29c. License	e number	2	9d. Date signed (Mor	nth, Day, Year)		
⊬ ≯⊨ ŏ		Danie V 1	Masta u	1	т	D 21438		04.N/	.06		
11		30. Name and address of person who completed	cause of death (Item 23)	a) (Type		21400		109	00.		
1011		Michael J. LaPenta, M				Annano1	is, Maryla	and 21401			
S	tate		82. Registrar's Signature			пород	,,				
Regis		APR 0 5 2006 🍂	was to	604	R. S.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4c,perMD, 354, 4/13/06 TT. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 3 2006ar Physician Jenkins Francine 31 12:10a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Black Baltimore Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 217-68-0049 Yrs Md 49 Director 2-1-57 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28a f show or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No NA Baltimore Md. Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 6200 Copore Way by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NA Disabled llth grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jenkins Eleanor Frances Lewis ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 ie
eny injury or other trau 1805 Sherwood Avenue Apt. B., Baltimore, Md. 21239 Desadra Jenkins Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-11-06 Randallstown, Md. King Mem. Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. Glade 1101 E. North Ave. March F.H. East 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ABDOMINAL CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month Year 4☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 1 ☐ Yes 2 ☐ No 2**X** No To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 😿 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To HOSPICE 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours e To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4372 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2008 Registrar

		1 - For State Registrar	State of Maryland		artment of F			ene g. No. 0	6 10468	
Physic /Med		1. Decedent's Name (First, Middle, Las FATRICIA	00.00			OHNSON 2. Date of Month MARC			Year 7.55 M	
Exami	П	4a. Facility Name (If not institution, give The JOHNS HOPK  5. Social Security Number  6. So	INS HOSPITAL	= st birthdav)	BALTIMO	RE CIT	У	4c. County	Birthplace (State or Foreign	
Funera Director		Usual Residence of Decedent	□M 2√xF 53	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 30	,1952	New York	
he Marylar 8a-f ehow	ector	Maryland Wicomic	10c. City, Town or Location Quantico				······································	10d. Inside City Limits 1 ☐ Yes 2 🛣 No		
th with ti 23s or 2	ai Dir	106. Street and Number 6520 Quantico Road 21856				10	10g. Citizen of What Country? U.S.A.			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: if item 27 is marked other then "natural", or iteme 23a or 28a-f show eny injury or other traumatic event, the Madical Examinar must be natified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates:	1	Vas Decedent of H I Yes, specify Cuba □ Yes 2 1 No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		e - American Indian, k, White, etc. : : White	
Z1Z15-UU36 ad within 72 hours af giene. er then "natural; or the Madical Exam	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retired tive Assi	during most of wor i)	rking 1		siness/Industry n Properties	
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ICE, Mar is 1 and 2 sho of Health and item 27 is m other traum		19a. Informant's Name/Relationship (7 Michael Pinto  20a. Method of Disposition	(Husband)	6520	Quantic	Road C	val Route Number, Quantico,	Mary1a		
Baltimore, bermit. Pages 1 ar Depertment of Hea mportent: if item my injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Met	ro Cr	sition (Name of natory or other place ematory	4-3	3-2006		ille, Maryland	
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Attending Physicien: The law requires thet the death certificate be executed XIV To death.  Sector: After this certificate has been signed by the ettending physician and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and position and posi		23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):								
		Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):								
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1					23d. Date of delivery  Month Day Y		
rds, P.O. quires thet the or signed by the	φ	Part II. Other significent conditions co						f tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Munknown		
Division of Vital Records, i or Attending Physicien: The law requires to effer death.  Director: After this certificate has been signed in by the funeral director, page 2 should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be to be a should be a should be to be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a should be a sho	Completed						autopsy performed? performed? performed? death?			
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To the within 2 To the complet	Z	29b. Signature and title of certified  Medical Dotton RES-000  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  MANISH ARORA, John Horkins Hospital,  31. Date filed (Month, Day, Year)  32. Projectors Signature,					29 M	29d. Date signed (Month, Day, Year)  MARCH 30, 2006,		
1/		30. Name and address of person who of ANISH AR	completed cause of death (Item 2 ORA, JoHN HolKII	23a) (Type, 1 05 HoS	Print) 60	o NORTH W	OLFE STREE	T, Ball	limore, MD. 21287	
Si Regis	ate trar	31. Date filed (Month, Day, Year)  APR 0.5 7	32. Pigistrar's Signatu	F A	andi)					

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	Disconici		1. Decedent's Name (First, Middle, Last)	)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Hilda F.	Jarzyns	ki			MARCH	30, 200	6 12:38PM
1	Examin		4a. Facility Name (If not institution, give s Saint Joseph	street and number) Medical Cer	nter	4b. City, Town, or	Location of Death	on	4c. County of Dea Bal	t timore
	Funeral Director		5. Social Security Number 6. Sec. 216-05-4182	M STYE	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Feb23, 1	9. Bir 915 Ma	thplace (State or Foreign cuntry) ryland
	pu .		Usual Residence of Decedent  10a, State 10b, County	100.0	ity. Town or Lo	antion				10d. Inside City Limits
	Aaryla r ehov	ō	Md. Baltime		undali					1 ☐ Yes 2 🖾 No
	28e-	rect	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	3a or	ID	6803 Bessemer	Avenue		212	22		USA	-
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or iteme 23e or 28e-f ehow other traumatic event, the Medical Examination must be nutified at	by Funeral Director		12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2♥ No If Yes, Give Year or Dates:			ispanic Origin? (Spe an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: W	te, etc.
5-0	72 ho 'natur	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	dent's Usual Occup	ation during most of works	ng 16	b. Kind of Business	/Industry
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9	e filed within al Hygiene. I other then '		8th 17. Father's Name (First, Middle, Last)		Adi	ministr		(First, Middle, Ma.	ocial S	ecurity
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Baltimore, Maryland	and 2 should be salth and Mental n 27 ie marked ier traumatic ev		19a. Informant's Name/Relationship (Ty Albert Jarzynsk	,			and Number or Rura Ave. Ba			Zip Code) and 21222
ore,	of Health Item 27		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place	ce) C	Pate 20	c. Location - City or	Town, State
<u>Ë</u>	Page nent d ant: ff ury or		N Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Sa	cred He	art of Ma	ary April			
Balt	permit. Pages Department of It Important: If Ite eny injury or of		21. Signature of Funeral Service Licens Townt							1 Home,PA d. 21222
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.				or respiratory arrest	,	Approximate Interval Between Onset and Death
П	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		TESTINA	L BLEED			5 HOURS
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P.O. Box (	death certii e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 nonths? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fer 4 □ Pregnant at time of 9 □ Unknown	aldeath 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	olivery Day Year
	ires thet ti signed by I be detac		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
rds		ed by	THORACIC ANEURY	SM REPAIR				1 🗆 Yes	2 □ No 3 □ P	robably 4 Unknown
eco	e law requ hes been je 2 shoul	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
Œ	The ste h page	Com						performe	d? death? No 1 ☐ Ye	1
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of	Physicien: rthis certific ral director,	<u>۲</u>	1 ☐ Yes 2 No	1 ☐ Inpatient 2 €	28b. Time of		4   Nursing no	me 5 Residence 28d. Describe how	e 6 Other (Spe	ecify)
O	ding th. Th. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	EGG. Describe now	injury occurred	
Division of Vital Records,	or Attending effer death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, str			28f. Location (Stree City or Town, S	et and Number or F	ural Route Number,
Ö	itel or irs efte ral Dir led in	Cer		building, etc. (epoc				July 3. 7 July 3.		
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			> Savinder	Elula	MD	D 8.	7188	-	3/3/10	06
	6		30. Name and address of person who co	empleted cause of death (Ite	m 23a) (Type,	Print)			1	
	Ψ		SAVINDER JULKA			ER DRIV	E TOWSON	, MARYL	AND 212	214
3	Sta Registr		31. Date filed (Month, Day, Year)  APR 0 5 20	32. Registrar's Sign	nature	alle				

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** KLUCKHUHN MARCH 29 2006 6:00 AM ROBERT MILES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign **Funeral** Months XXM 2 F Maryland 87 Yrs Nov. Director 578-16-0393 11, 1918 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20707 USA 1200 Montgomery Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after XYes 2 □ No fYes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White ģ If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "ne any injury or other traumatic event, the Medical COLO." Elementary/Secondary (0-12) College (1-4or 5+) 12th Owner Fuel Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick George Kluckhuhn Daisy Pearl Miles ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20707 Richard Kluckhuhn/Son 5808 Maple Terrace, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Ft. Lincoln Cemetery 4/1/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD M00160 284. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 18 Months Immediate Cause (Final Alzheimer's Disease **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown څ Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed pe Urinary Tract Infection 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2CXNo 24a. Was an autopsy ONKK 1 Yes in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation s after death 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 2 D39532 3/29/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 321 Prince George Street, Laurel, MD McClain, MD 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ISHMARL 3 KUTUBU 06 /Medical 4b. City, Town, or Location.

SILVER SPRING

If Under 1 Year If Under 24 Hrs.

Hours Min. (Month, Day, Year)

On the Days Hours Min. (Month, Day, Year) 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY CROSS HOSPITAL HOLY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Yrs. MID Director none Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits rai', or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No PRINCE GEORGE'S MONTPELIER Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code MUIRKIRK 20708 9526 USA KD # 102 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK ğ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any lighty or other traumatic event once. AHMED KUTUBU DAGMAR NGIOWA 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PARENT 9526 MUIRKIRK RD #102 MONTPELIER MD 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ☑Other (Specify) in/state 21. Signati - of Funeral Service Licenses State Anatomy Board 655 W. Baltimore Street mall Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** prematurity /Medical Due to (or as a conséquence ol): Examiner COMPETER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence ol): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number W 03-27-2006 D4410130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 DARREH BAND GEOF GIA IVE STE 101 SILVER SPORT IND 10901 31. Date liled (Month, Day, Year) 32 Registrar's Signature State APR 6 5 Registrar Gestle

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2	07		30. Name and address of person	who completed car	use of de	ath (Item	23a) (Type	Print)	50	TO1	NSUN	N	, D	212	04	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 5	2008	Registra	r's Signat	ure	ales		1	,				-	

			State of Maryland / Department of Health and State Certificate of Death		giene Reg. No. UU 6	0475
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Hazel G. Litvinuck	2. Date of Dea Month	of 2006	3. Time of Death $J:30 \text{ PM}$
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c. City, Town, or Location of Dea  4c		4c. County of De	ath  Significant  State or Foreign
	Funeral Director	i i	216-09-1804 1 M 2 F 88 Yrs. Months Days Hours Mir	March	v. Year)	aryland
	ith the Maryland or 28a-1 show	lor	10a. State 10b. County 10c. City, Town or Location  Maryland Worcester Ocean City			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the lace or 28a-	Direct	10e. Street and Number  9011 Mediterranean Drive  21842		10g. Citizen of What	-
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturs!", or Items 23a or 28a-f show sny injury or other treumatic svsnt, the Modecal Extrudent must be notified at once.	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No arto Rican, etc.)		nerican Indian, nite, etc.
-0036	hours af turs!', or	ed by	3 ★ Widowed 4 □ Divorced If Yes, Give 1 □ Yes 2 ★ No Specify: Year or Dates:		Specify:	White
Maryland 21215-0036	I within 72 iene. r than "na the Medic	Completed by	(Specify only highest grade completed)  Elementary/Secondary (0-12)  12th Grade  College (1-4or 5+)  Homemaker	orking	Own t	
land 2	id be filed enta! Hyg ked other ic svsnt,	To Be C		ame (First, Middle, Gorma		
Mary	d 2 shou th and M 17 Is mar treumati	-	19a. Informant's Name/Relationship (Type, Print)  Martha Senkbeil (personal rep.)  44 Henry St., 3rd F.			
ore,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	or Town, State
Baltimore,	permit. Pa Departmen Important: sny injury 2009.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility S	chimunek		omes
	20 E * 0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.			Approximate Interval Between
0	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Sep 515  Due to (or as a consequence of):			Onset and Death
1804	Examiner	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury)			hours
4 fm	cate be executed physicien and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
60-03 430 68760	tificate be g physici as the bu	ledical	d			
2/ 0. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of Month	delivery Day Year
ds, P	uires that signed b Id be deta	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?  Probably 4 Unknown
142 30 2		Completed		24a. Was autor perfo	osy prior death	autopsy findings available o completion of cause of ?
Ck Vita	Physicien:   rthis certifical ral director, p	Be	examiner?	Home 5 Resi	one) dence 6 □Other (S	neciful
11918 1000	ing Afte une	atlon: To	27. Manner of Death 1		how injury occurred	oociiy)
4.17 3//6 Divisi	i i i i	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location ( City or Tot	Street and Number or wn, State)	Rural Route Number,
	To the Hospitel within 24 hours a To the Funerel to completely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	curred at the time,		
	To th within To th comp	Me	29b. Signature and title of certifier  **Europe Deligner MO C1-000679.		3-31-06	
	12					
	Sta Regist		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KR (ST) KE GR (FRV) MO 1209 CVASTAC H16HWAH,  31. Date filed (Month, Day, Year)  APR 0 5 2006			•

NLM	16		U npend item#23a,27,pe	ype or Print in B ::::::::::::::::::::::::::::::::::::	Tack Inde	ment of t	. Ensure A Tealth and	<b>VII Copies</b> Mental Hv	Are Le aiene	gible.	1 25 1	شر و تع
06-022 Issac			1 - State Registrer	, ,		ficate of			Reg. No.	U6	Market Annual Control	1/6
	Physici		1. Decedent's Name (First, Middle, Last)  Issac Joonho Le	ee				2. Date of De Month Marc	Day	Year 2006	3. Time	of Death
	/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)	4	b. City, Town, o	or Location of Deat			inty of Death		10 A
10			St. Agnes Hospi			Baltimo						
14/1	Funeral Director		218-09-4797	7. Age (In yrs. I		f Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da June 7	v. Year)	i Cou	place (State ntry) Land	or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Local	ion			<del></del>		10d. Inside	City Limits
	r 28a-f ahow	Funeral Director	Maryland Howard  10e. Street and Number		E1k	ridge			10g Citizon	of What Cou		s 2 🙀 No
	\$ 0 M	i Dir	5881 Critter Court			210	75		U.S.		iitry :	
	deeth	nera		Was Decedent Ever in U.     Armed Forces?	S. 13. Wa		Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No		Race - Americ Black, White,		
Baltimore, Maryland 21215-0036	72 hours after deeth v natural', or Iteme 23s otch Expoliner must	by	1 Never Married 2 Married  3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Yes 2⊠ No	Specify:	to mount, etc.,		ecify:	sian	
5-0	72 hours "natural"	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give kin	t's Usual Occup d of work done	during most of wo	rking	16b. Kind o	of Business/In	ndustry	
121	within iene. then "r	mpl	Elementary/Secondary (0-12)  n/a	College (1-4or 5+)	n/	NOT use retire	(d)		n/	а		
d 2	filed Hygie other		17. Father's Name (First, Middle, Last)			<u> </u>	18. Mother's Na	me (First, Middle,				
<u>a</u>	Ald be fental riked of tic even	To Be	Tony Lee				Bok 1	Lee				
ary	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then other traumatic event, Ita Mi		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Street	and Number or R		•			
≥ ∞	and sealth m 27		Tony Lee (Father)	loop B	Annual Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the Control of the	Critter	Court 1	Elkridge				
JO.	in it of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	moval from State	lace of Dispositi emetery, cremat	ory or other pla		Date		on - City or To		
퍑	permit. Pages Department of I Important: If its eny injury or of		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		tro Cre			3-2006		sville	, Mar	yland
Ba	Depart Import eny in		1/2/1/1/	1/	Wi	tzke Fu	neral Hot Knolls	mes, Inc	lumbia	Mary	land	21045
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.	. Do not enter	the mode of dy	ng, such as cardia	c or respiratory a		, mary	Approxima Interval Be Onset and	ate etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Complications of		a A Vira	1 Infection	1				
	Examiner			Due to (or as a consequ	ience of):							
	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (ui as a consequ	тепсе ођ.							
	e be executed /sicien and e burial-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last									
760,	oe exe cien a ourial-	alEx	resulting in death) Last	Due to (or as a consequ	ience of):					1		
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Вох 6	leath certificate attending phys I for use as the	√Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d.	Date of delive	ery	
O. B.	he death the atte	by Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		topic pregnanc ther (specify) _	y 			Month	Day	Year
s, P.O.	res thet the de signed by the a I be deteched t	by Ph	Part II. Other significant conditions cont	ributing to death but not resu	ilting in the unde	rlying cause gr	ven in Part I.		3.7	contribute to t		
ord	v requir been si should i	ted			· · · · · · · · · · · · · · · · · · ·			1 🗀 🕆	Yes 2ÅN	3 ☐ Prot	bably 4	]Unknown
Rec	e ia hes je 2	Completed								death?	opsy findings empletion of 2 \bigsi No	s available cause of
/ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of De	ath (Check only o	-	1		
<u>\$</u>	Physicia this cert al direct	၉	123,103 2 100			3L DOA		lome 5 Resid			fy)	
u o	ding F h. After funer	tion	27. Manner of Death  1 \( \bar{\lambda} \) Natural 5 \( \bar{\lambda} \) Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ryat rk? ]Yes 2∐No	28d. Describe I	now injury oc	curred		
ć	l or Attendi after death. Director: A in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify				28f. Location ( City or Tox		ımber or Rura	al Route Nu	m <i>ber</i> ,
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier (Check only one)  1 ☐ Certifying Physical Examina (Check only one)	cian: To the best of my know er: On the basis of examinat and manner stated.	wledge, death or ion and/or inves	ocurred at the ti	me, date and place	e, and due to the urred at the time,	cause(s) and date and pla	manner as s ce, and due t	stated. to the cause	(s)
	To the within ? To the	Mec	29b. Signature and title of certifier	2114 1114111141 3(8(84).		29c. Licens	se number			gned (Month,		
	->=0		> Carocita	llan wy		OC	ME		March	31, 2	006	
			30. Name and address of person who con		23a) (Type, Pri		nn Street	Balti	more.	Maryla	nd 21:	201
	Sta	ate	31. Date filed (Month, Day, Year)	#32. Registrar's Signar	ture				,			
	Registr	ar	APR 0 5 2006	Aller A.	Asside							

			. FOI	partment of Health and Me ertificate of Death	ental Hygiene	006 10477
	\$ 1. ×		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
**	Physici /Medic	_	Mildred A. Lowenste	in	Month Day	2006 11.33 AM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. (	County of Death
			GOOD SAMARATAN HOSPITAL	BALTIMORE		N/A
Ÿ.,	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
A C	Director		213-10-1317		Sept 9, 1919	A MO
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or t	Location		10d. Inside City Limits
	Mary	to	MD N/A	BALTIMORE		1 Yes 2 No
	28a	rec	10e. Street and Number	10f. Zip Code	10g. Citiz	zen of What Country?
	h with	D E	3136 Kenyen Ave	21213		U-S.A.
	deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13 Armed Forces?	. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	Race - American Indian,     Black, White, etc.
98	or Ite	Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☑ No Specify:		Specify: 1. 1. T
5-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Madical Examinar mual be notified at	d by	3 Widowed 4 Divorced Year or Dates:		10h Kis	nd of Business/Industry
15-	n 72 n "nat	iete	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of workin DO NOT use retired)	9	id of business/industry
2121	filed withi Hygiene. Ither than	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Home.
	illed Hygie other	e C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maiden	Sumame)
lar	Mental arked o	To Be	EuGene Airey	BARBAR	A WACK	CR.
Maryland	2 sho and h is ma			ling Address (Street and Number or Rural		
	and 2 ealth m 27 i	10		. Kenyen Ave. BA		
ore	of H		art Burgat 2   1Cramation 3   Bamovat from State	position (Name of ematory or other place)		cation - City or Town, State
Baltimore,	. Pag tment tent: jury		4 Donation 5 Other (Specify)	+ GAITH 17/4/0	ROSE	edale MD
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show amportent: or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Funeral Service Licensee  Vaul M Stella	2. Name and Address of Facility AUL STELLA FUNERAL 7527 HATERD RD.	BA Ito MD	21234
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
2000	Physician		Immediate Cause (Final disease or condition Massive Int	rackural Heno	ehage	Oliset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1 0	0 \	
Ю		-	Sequentially list conditions, if any, leading to immediate  b. TRAUMC To  Due to (or as a consequence of):	nead		<del>- }</del>
V	betr	Examiner	Cause (Disease or injury	TOPENIA		111
10	be executed sician and burial-transit	Еха	resulting in death) Last		1 -0	/ UNI
120	A × 6	icai	La Upper gasti	o Intestined B	CATION APPROVED BY M	ENICAL EXAMINER
89	ng ph	Med	IF FEMALE:	AEDTIF	CATION APPROVED BY W	
Вох	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the eact 13 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy	2	23d. Date of delivery  Month Day Year
	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the burial	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5	Other (specify)		,
P.0	that ti ed by detac	4	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco u	se contribute to the cause of death?
ds,	uires sign d be	d by	Syncope		1 ☐ Yes 2 [	□No 3 □ Probably 4 □ Onknown
202	w req beer shou	lete	Demente		24a. Was an	24b. Were autopsy findings available
Records,	he lav e has age 2:	Completed			autopsy performed?	prior to completion of cause of death?
ta	en: T tificat tor, pa	a	25. Was case referred to medical	26. Place of Death	(Check only one)	1 ☐ Yes 2 ☐ No
<u>&gt;</u>	Physicien: this certificatal director,	To B	examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing Hom	ne 5 ☐ Residence 6	G □Other (Specify)
0 L	ding Physicien: The I h. After this certificate ha funeral director, page		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	Work?	8d. Describe how injury	
Si	Attending in death.	catic	2 Accident investigation march 38,2006 + or	AM 1 Yes 2 No		11 on STEP
Division of Vital	or Att	Certification:	4 Homicide determined building, etc. (Specify)	0. 0	City or Town, State,	
	pitel ours a erel C	ပိ	29a. Certifier 12 Certifying Physician: To the best of my knowledge, de			NAUC 21213
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only one) 2 Madical Examinar: On the basis of examination and/or and manner stated.			
	To th Within To th	Me	29b. Signature and title of certifier	29c. License number	1	e signed (Month, Day, Year)
	0		Human ms	RE5000	3	129)76
			30. Name and address of person who completed cause of death (Item 23a) (Typ	a Print)	1 1 1	1576
	V		HIRAIDA HANNOUSh 5601 1	och RAVER BLUD BI	011-410	(1837)
23	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	ach s		
18	Regist	ell oc:	APR 0 5 2006			

			1 - For State Registrar	State of M	aryland / De	partmer <i>ertifica</i>			Mental H	lygien Reg. N	7 11 11	6	10478
п	Dhysisi		Decedent's Name (First, Middle, Last	st)					Date of Month	Death Da	av	Year	3. Time of Death
-	Physici /Medi		Barbara		Ann		Lew	is	Marc	0 3		006	17.17 PM
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or I	Location of De	ath	40	c. County o	f Death	
			Smar Hospita	1 of Bal	timore	Balt	mor	e Citi	1				
	Funeral		5. Social Security Number 1 6. S	ex 7. Ag □M <b>X</b> □F	e (In yrs. last birtho	Months	Days	Hours Mi		Birth Day, Year	)	<ol> <li>Birthpla Countr</li> </ol>	ice (State or Foreign
	Director		218-62-0836		53 Yrs	5.			01	26	53	M	ID
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town o	r Location						10	d. Inside City Limits
	lanyi.	5	MT		Balti								1 <b>∑</b> Yes 2 □ No
	28e-1	ect	MD NA  10e. Street and Number		Baici		p Code			100 C	itizen of W	hat Causti	
	with a or	급	5102 Belleville	ο Δυο		101. 21		207		109.0	U.S		y r
	72 hours after death with the Maryland naturel', or iteme 23a or 286-1 ehow lites Examinar must be notilled at	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13 Was Dece			(Specify Yes or	No.		- America	n Indian
	ter d	Į.	1 □ Never Married 34□ Married	Armed Forces?	No	If Yes, spe	ocify Cuban	, Mexican, Pu	(Specify Yes or erto Rican, etc.)			, White, et	
36	irs af	by F	3 Widowed 4 Divorced	XXYes 2☐ If Yes, Give Year or Dates:		1 🗆 Yes	20 No	Specify:			Specify:	в1	.ack
21215-0036	the sture	ed	15. Decedent's Ed	ducation	16a. D	ecedent's Usu	ual Occupat	tion		16b. i	Kind of Bus		
15	n n	Completed	(Specify only highest gra		(C	Rive kind of wo fe. DO NOT u	ork done du	iring most of w	vorking				•
212	y with	Eo	12th grade	College (1-4or ! na		Army				U.	S. M	ilit	ary
D	Hygothe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Mid	dle, Maide	n Sumame	)	
a	lenta Red rked	To B	Raymond Clark					Mary	Brooks				
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan to Heelih and Mental Hygiene. If Item 27 is marked other than "nature!, or iteme 23a or 28e-f show or other traumatic event, the Medical Examinar must be notified at	_	19a. Informant's Name/Relationship (	Type, Print)					Rural Route Nu				
	and 2 selth a 27 ic		Raymond Clarke	-Father	510	)2 Bel	llevi	ille A	ve, Ba	ltim	ore,	Md	21207
<u>6</u>	f Her item othe	1 3	20a. Method of Disposition	,	20b. Place of D	sposition (Na	me of	i 1	Date	20c. l	ocation - C	City or Tow	n, State
e E	Page ent o nt: if ry or		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 1)		1	dlawn	ourier prace		/06	Bal	timo	re C	Co, Md
Baltimore,	permit. Pages 1 and 2 Department of Heelth a Important: if item 27 ie eny injury or other trae	١.	21. Signature of Funeral Service Licer			22. Name a	nd Address	of Facility					
ä	Depar Impo		* Chopine A.	Shimo	RM	March	n F/F	H West	e, Bal	rimo	re.	Mđ	21215
			23a. Part1. Enter the disease, or com shock in heart failure. List only	plications that caused	the death. Do not						HOLL HIVE		Approximate
J	Photototon		shock or heart failure. List only Immediate Cause (Final		no. etastat								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence of)		Brea	26 (0	incer				3 yrs.
	Examiner			-	olmoni		em	bolu	5				
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	a consequence of)								
*	oned I ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
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8760,	tate be executed thy sicien and the burial-transit	dicai	(	d									
.89	ificat g phy as the	edi										and)	
Box	eath certific ettending pl I for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		. ==				ļ	23d. Date	of deliver	y
ă	death e etten id for u	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant a	2 ☐ Fetal death t time of death	3 ☐ Ectopic p 5 ☐ Other (s					Mon	th [	Day Year
0	the ty th	hysi	9 Unknown	9□ Unknown									
<u>a.</u>	requires that sen signed b nould be deta	by PI	Part II. Dther significant conditions of	ontributing to death b	ut not resulting in th	e underlying	cause giver	n in Part I.	23e. D	id tobacco	use contri	bute to the	cause of death?
Division of Vital Records,	quire; n sig	D D							1	☐ Yes 2	28 No ∶	3 🗌 Proba	bly 4 □Unknown
S	7 7 7	Completed							24a. W	÷ Masan	24b. W	ere autops	sy findings available
Re	0 5 0	m C							P	utopsy erformed?	pr	ior to comp eath?	pletion of cause of
a	ticien: Th certificate rector, pag	ပိ	25. Was case referred to medical	· · · · · · · · · · · · · · · · · · ·				OS Disease of C	1 Te		0 11	☐ Yes 2	! <b>≥</b> CNo
Ξ	Physicien: this certific ral director,	0	examiner?	Hospital:	ent 2 ER/Outpa	tiont 200	Other	-	eath (Check or Home 5 ☐ R		6 DOth	(0 6)	
of	Phy rthis	- To	27. Manner of Death	28a. Date of Inju (Month, Da			28c. Injury Work	4   Nursing	28d. Descri				
on	ding h. Afte fune	tlor	1 Natural 5 Pending 2 Accident investigation		y Year) Inju	ry M		? es 2 □ No			,		
<u>:S</u>	dead ctor y the	Certification:	3 ☐ Suicide 6 ☐ Could not b	a	ury - At home, farm	. street, factor			28f. Locatio	n (Street a	nd Numbe	r or Rural	Route Number,
Ö	after Dire	erti	4 Homicide determined	building, et	c. (Specify)	,,	,,,		City or	Town, Sta	re)		,
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Ph	ysician: To the best	of my knowledge of	eath occurred	d at the time	a, date and pla	ice, and due to	he cause/	s) and man	ner as sta	ted.
	24 h 24 h Fui	edicai	(Check only 2 Medical Exar	niner: On the basis o	f examination and/o	r investigation	n, in my opi	nion, death oc	curred at the tin	ne, date ar	nd place, a	nd due to t	he cause(s)
	ompl	₩.	29b. Signature and title of certifier		· · · · · · · · · · · · · · · · · · ·	29	c. License	number		29d. D	ate signed	(Month, D	ay, Year)
	,- > F- 0		Al Ragalli	1/-	MD	P	FC-	15790	4	M	wh	7/	,2006
	14/		30. Name and address of person who	completed cause of			>	/ 6	7	,,,,	., ., ,	30	12006
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	Str	ate	31. Date filed (Month, Day, Year)			AP .		1 4			, (, ,		

,			1 - For State Registrar	State of Maryland / Dep Ce	artment of Health and I	Mental Hygier	.000 10712
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medi		Charles Marion Luc	cas		March 30,	2006 4:15p M
	Examir		4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Deat		4c. County of Death
			1514 Furnace Avenue	2	Glen Burnie	Ar	nne Arundel
	Funeral		Social Security Number     6. Sex	7. Age (In yrs. last birthday		8. Date of Birth	9. Birthplace (State or Foreign
	Director		230-16-6227	M 2□F 81 Yrs.	Months Days Hours Min.	(Month, Day, Yea August 11.	, 1924 Virginia
	ը _		Usual Residence of Decedent				
	show	_	10a. State 10b. County	10c. City, Town or L			10d. Inside City Limits
	Ba-f	cto	Maryland Anne Arun	ndel Glen Burn	1e		1 ☐ Yes ¾☐ No
	or 2	Director	10e. Street and Number		10f. Zip Code	10g. 0	Citizen of What Country?
	23a		1514 Furnace Avenue	<u> </u>	21060	Ţ	JSA
	ter dea Items Iter of	Funerai		Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1  Yes 2 No 43-46	1 ☐ Yes 2 ☐ No Specify:		Specify:
8	72 hours after death with the Maryland natural', or Items 23a or 28a-f show ites! Ess offer must be motified at	d b	3 Widowed 4 Divorced	Year or Dates:			White
5	nat	Completed	15. Decedent's Edu (Specify only highest grade	completed) (Give	edent's Usual Occupation a kind of work done during most of woi DO NOT use retired)	king 16b.	Kind of Business/Industry
12	within iene. than "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	•	11 0	Feedy Feeds 7
22	be filed within 72 hours after death with the Maryla ital Hygiene. d other than "natural", or items 23s or 28s-f show event, it e Madical Exeminer must be notified at		17. Father's Name (First, Middle, Last)	Weld		ne (First, Middle, Maide	S. Coast Guard Yard
au		Be					an Sumanne)
Maryland 21215-0036	s 1 and 2 should be f Health and Mental Item 27 Is marked other traumatic ev	ဌ	Samuel Henry Luca  19a. Informant's Name/Relationship (Tv.)		Elsie   Ing Address (Street and Number or Ru	Wolfe	cor Town State Zin Code)
Za	- m m =			i nomes as		Sal to	
	ss 1 and 2 of Health item 27 I		Elizabeth Lucas - wi 20a. Method of Disposition	20b. Place of Disp	Furnace Avenue, (		Location - City or Town, State
<u></u>	m O		1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State	matory or other place)		
Baltimore,	- モモラ	1	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>		<ul> <li>Memorial Park  4/3/2</li> <li>Name and Address of Facility</li> </ul>	2006 E1k	cridje, MD
Ba	Depariment Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department Department		A 4	201214	Gary L. Kaufman Fi	uneral Home	at MMP, INC.
				cations that caused the death. Do not er	7250 Washington B	lvd., Elkri	dge, MD 21075 Approximate
			shock, or heart failure. List only on Immediate Cause (Final	ne cause on each line.	io in thous of dying, such as sarate.	or respiratory arrest,	Interval Between Onset and Death
橿	Physician /Medical		disease or condition resulting in death)	Cym or	10mg		1 month
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		P.	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):			
	uted Insit	in in	cause. Enter Underlying Cause (Disease or injury) that initiated events	,			
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8760,	cate be executed physician and the burial-transit	dical		1			
.89	Ph Ca	- 00					
Вох	death certifi e attending   id for use as	M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy			23d. Date of delivery
m	death a atte	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
0	y th	Physician/M	9 Unknown	9□ Unknown			
<del>ر</del> .	ge g	by P	Part II. Other significant conditions con	tributing to death but not resulting in the t	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Records,	quires in sign uld be					1 Tes	2 No 3 Probably 4 Unknown
00	w requir s been si should	iete				24a. Was an	24b. Were autopsy findings available
Re	The lav	ompieted				autopsy performed?	prior to completion of cause of death?
Vital	(0 -	Ö	25. Was case referred to medical		26 Place of Dea	th (Check only one)	lo 1 Yes 2 No
>	Physician: this certific ral director,	OB	examiner?	ospital: 1 Inpatient 2 ER/Outpatie	Other	ome 5 Residence	6 Other (Specify)
o		P. T	27. Manner of Death	28a. Date of Injury 28b. Time of	of 28c. Injury at	28d. Describe how inj	
lon	불무절	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	or Attendi after death. Director: A in by the fu	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, st	reet, factory, office		and Number or Rural Route Number,
ā	al or A s after al Dire	Cert	4 _ Homicide	building, etc. (Specify)		City or Town, Sta	( <del>a</del> )
	e Hospital 24 hours a e Funeral I letely filled		29a. Certifier  (Check only 2 Medical Examin	ician: To the best of my knowledge, deal	h occurred at the time, date and place	, and due to the cause(	s) and manner as stated.
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	one) 2 Medical Examir	ner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date a	nd place, and due to the cause(s)
	To the within 2. To the complet	Σ	29b. Signature and title of certifier	11/2-11	29c. License number	29d. D	Pate signed (Month, Day, Year)
)	14		* Durolle		6)3/15	1 19	10ch 31, 2006
	17/1		30 Name and address of person who co	mpleted cause of death (Item 23a) (Type,	Print)	( )	arc/31,2006)
_	121		Kussell ali Dellu	1,00° 305 Ho	25 milal (Dive	8/20 B	D41017, 14. 2106)
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	20		,
	. Registr	ar	ADD OF SOME	Malana A Alexa	Me		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Hazel Griffin Louk April 2006 12:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Severna Park Center Severna Park If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2 🖾 F 86 **Director** 228-16-7995 July 21 1919 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County in then "neturel", or Items 23e or 28e-f show the Medical Examinat must be notified at 1 ☐ Yes 🏋 No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? .155 Truck House Road 21146 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 2 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lee Taylor Robertson Mamie Owens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ellison (Daughter) 155 Truck House Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I permit. Pages
Department of Importent: If it
eny injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Memorial Park 4/5/06 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, Inc
7250 Washington Blvd. Elkridge, MD 21075 21. Signature of Funeral Service Licensee 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the art failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician (ARDIOMY OPATHY /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 1 Yes 2/ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: To the Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) hours after within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier APRIL 3 rson who completed cause of death (Item 23a) (Type, Print) BACTIMORE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2006 Registrar

		•	1 - For State Registrar	State	of Maryla		artment of F rtificate of I			-	giene Reg. No	UUU	M A CANADA	0 8
*	60		Decedent's Name (First, Middle)	, Last)						2. Date of De	ath			3. Time of Death
	hysici		Rosemary Li	indnor						Month April	Da <b>1</b>	2006	ar	10:30am <sup>M</sup>
	/Medic		4a. Facility Name (If not institution,		umber)		4b. City, Town, or	r Location o		Thrit	4c	. County of E	eath	10:30am
	Aannii	iei	Maria Healt		Cente	r	Baltimo	re	MD			Balt	imo	re
E	poral			6. Sex		rs. last birthday,	tf Under 1 Year	If Under	24 Hrs.	8. Date of Bir	th			ace (State or Foreign
	ineral ector		219-14-5037	1□M 2₩F	82	Yrs.	Months Days	Hours	Min.	(Month, Da June (				yland
. 3-			Usual Residence of Decedent		02					o and			mai	y Lanu
yian	P P		10a. State 10b. County		10c. (	City, Town or L	ocation						10	d. Inside City Limits
Mai	Filed	ţò	MD Balti	imore	E	Baltime	ore						1	1 ☐ Yes 2 ☐ No
h the	28	Director	10e. Street and Number				10f. Zip Code				10g. Ci	tizen of Wha	t Count	ry?
Ë M	23a c	aiD	6401 N. Ch	narles	St.		21	212				USA		
d (12.15.15.15.15.15.15.15.15.15.15.15.15.15.	ral', or items 23a or 28a-f ehow Examinar must be notified at	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of H	lispanic Ori	gin? (Spe	city Yes or No	)-	14. Race - A Black, V		
after	하는	교	X Never Married 2 ☐ Marri	ed 1 Tes	2 <b>N</b> O		1 ☐ Yes 2 X No	Specify:	1, 1 00110 1	mount, otc.,		Specify:		
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72 h	"natural", edical Exe	Completed	15. Decedent' (Specify only highes	s Education	)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during mos	t of workii	ng	16b. K	and of Busine	ess/Ind	ıstry
ithin e		idu	Elementary/Secondary (0-12)	College	(1-4or 5+) 🚧	9.1		1)						
y be w	100	S		Teache	r Cert	T .	eacher						a 1	School School
tal fi	event, the Medical	Be	17. Father's Name (First, Middle, L	.ast)				18. Mothe	er's Name	(First, Middle	, Maider	i Sumame)		
should be	arke	은	George_Line							eth A				
2 sh and	Taum Taum		19a. Informant's Name/Relationsh				ng Address (Street							
and ealth	m 27 her t		Bernice Fei	llinger	1001		N.Charl	Les S						
Pages 1 Pent of He	7 to 1		20a. Method of Disposition 1 ⊠Burial 2 ☐ Cremation	3 ☐Removal from	State	cemetery, cre	osition (Name of matory or other place			ate / / / / / / / / / /		ocation - City		
Pag	ury c		4 Donation 5 ☐ Other (Sp		Vi	.11a Ma	aria Cem	neter	У '	1/4/06	G16	en Arı	m,	MD
permit. Depart	Important: if Item 27 le marked other then any injury or other traumatic event, the Monte.		21. Signature of Funeral Service L	epken/	Kener.	6	2. Name and Addre tchell-V			đ 6500	) Yo	ork R	đ.	Baltimore
			23a. Part1. Enter the disease, or shock, or heart failure. List of	omplications hat	caused the de	eath. Do not en	ter the mode of dyin	ng, such as	cardiac o	r respiratory a	rrest,			Approximate Intervat Between
Phys	ician		Immediate Cause (Final disease or condition			UMCL	14							Onset and Death
	dical		resulting in death)	Due to	o (or as a cons									
Exar	miner		Sequentially list conditions,	b										
D	=	Examiner	if any, leading to immediate cause. Enter Underlying	Due to	o (or as a cons	equence of):								
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cate be executed	physic the b	dicai	N	d									-	
	ng p	Mec	IF FEMALE:											
E G	attending for use as	Physician/Me	23b. Was decedent pregnant	23c. If yes, o	utcome of preg birth 2  Fe	gnancy etal death 3[	⊒Ectopic pregnancy	,				23d. Date of Month		
- de	he at ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg 9☐Unk	nant at time of	f death 5[	Other (specify)					NOTITI	,	Day Year
at the	by the stached	Ph.	9 □ Unknown Δ							1				
The law requires that the death certifi	signed d be det	þ	Part II. Other significent condition  CCL 6-R5710	ns contributing to	death but not re	esulting in the t	Inderlying cause giv	en in Part I.			obacco Yes 2			bly 4 Unknown
in be	been si should	Completed								''	105 2	NO 3		bly 4 DOTKHOWN
N W	5 CM	ble.	DIABRTES	MARI	2170					24a. Was	psy	24b. Were	e autop	sy findings available pletion of cause of
	e g	Con								perfo 1 ☐ Yes	rmed? 2 ⊡xNo	deat	h? Yes :	2 🗆 No
	als certificate director, pag	Be (	25. Was case referred to medical examiner?					26. Place	of Death	(Check only	опе)			
yaic	9 TO	2	1 ☐ Yes 2 😾 No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3□ DOA Oth	er: X Nu	irsing Hor	me 5□Resi	dence	6 Other (	Specify	
- 5	After the funeral of	1 1	27. Manner of Death 1 ▼Natural 5 □ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time o	of 28c. Injury Wor	y at k?	2	28d. Describe	how inju	ry occurred		
endi	or: A he fu	atio	2 Accident investig	ation				Yes 2 🗆	No					
r Att	recto	ertification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 200. Flat	e of Injury - At	home, farm, st	reet, factory, office		2	28f. Location ( City or To			r Rural	Route Number,
rs aft	ed in	Cer												
To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	ne best of my k basis of exami nner stated.	nowledge, deal nation and/or in	th occurred at the tin evestigation, in my o	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s date an	and manne d place, and	r as sta due to	ited. the cause(s)
To the within	To the	M	29b. Signature and title of certifier	/		0	29c. Licens	e number			29d. Da	ite/signed (M	fonth, D	ay, Year)
			trus	9 2-1	/ nun	d	Da	137	3	į	41	3/00	5	
10	V		30. Name and address of person v	who completed car	use of death (It	tem 23a) Type.	Print)		<u></u>		-/-	1		
1	1		Dr. F. Carmo					びばせへか	МЪ	2120	14			
	Sta	te	31. Date filed (Month, Day, Year)	M.	Registrar's Sig	nature	Drive To	MOOT			<u> </u>			
7	Registr		APR 0 5	2006	MARI A	T. Marie								

			1 - For State Registrar	State of Ma		partm		ealth and			U o	10482
	Physic	ian	1. Decedent's Name (First, Middle, Last,						2. Date of De Month	eath Day	Year	3. Time of Death
	/Medi	cal	Kenneth P. Mose						April			1:15 p M
	Examir	ner	4a. Facility Name (If not institution, give : 16 Lake Drive	street and number)		4b. (	City, Town, or Be1	Location of Deal	th		anty of Death	
	Funeral Director		5. Social Security Number 6. Security 12-24-8454	_	(In yrs. last birthd 4 Yrs	Mon	nder 1 Year iths Days	If Under 24 Hrs Hours Min.		1	9. Birth	place (State or Foreign Intry) Orgia
	pur *		Usual Residence of Decedent  10a. State 10b. County		100 City Town							
	he Maryla :8e-f sho	Director	Md. Harford		10c. City, Town o	Bel A	Air					10d. Inside City Limits 1 ☐ Yes 2 ☐ No X
	a or 2		10e. Street and Number 16 Lake Drive			10f	. Zip Code	01/		10g. Citizen		intry?
	Jeath ns 23	Funerai		12. Was Decedent E	ver in U.S.	3. Was D		.014	Specify Yes or No		S.A.	ican Indian
036	urs after o al', or Iter	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☑ Yes 2 □ N If Yes, Give Year or Dates:			specify Cuba		Specify Yes or No to Rican, etc.)		Black, White	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland stal Hygiene.  Id other than "natural", or Items 23a or 28e-1 show event, Ira Medical Exercitor must be multiled at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		—— (G	icedent's l ive kind or e. DO NO	Usual Occupa if work done d oT use retired,	ition uring most of wo	rking	16b. Kind o	f Business/Ir	ndustry
2	filed wil Hygien other th	Con	, , , , , , , , , , , , , , , , , , , ,	4		ginee	er			U.S.	govern	nment
yland	should be filed withir and Mental Hygiene. marked other than mattc event, It a Mis	To Be	17. Father's Name (First, Middle, Last) Asa Moseley						me <i>(First, Middl</i> e, e Elliot		name)	
	permit. Pages 1 and 2 should by Depermit of Health and Menia Important: If Item 27 is marked any Injury or other traumatic es once.		19a. Informant's Name/Relationship (Ty, Dorothy S. Moseley		16	6 Lak	ce Driv	e, Bel	Air, Md.			p Code)
Baltimore,	ges 1 t of Ho if Iter or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ R	emoval from State	20b. Place of Discemetery, of	sposition ( crematory	(Name of or other place	9)	Date	20c. Location	on - City or T	own, State
	t. Pa rtmen rtant:		4 ☐ Donation 5 ☐ Other (Specify)		Bayview				/2006	Balti	more,	Md.
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*	Physician but some specified by specified and specified and specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specified specif	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (o, as a	consequence of): consequence of):	end	iony	spull				Inierval Between Onset and Death
P.O. BOX 00	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death		ic pregnancy (specify)				Date of delive	ery Day Year
, L	ss that gned b	by Pi	Part II. Other significant conditions con		not resulting in the	underlyin	ng cause give	n in Part I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
3	equire een si		chronic rend	fulue.					1 🗆 Y	res 2□No	3 Prob	pably 4 Stinknown
DIVISION OF VITAL DECORDS,	Physician: The law r rthis certificate has be rral director, page 2 sh	Completed							24a. Was autop perfor	rmed?	b. Were auto prior to co death? 1 \(\sum Yes\)	opsy findings available impletion of cause of
Z	ician: Sertific ector,	Be	25. Was case referred to medical examiner?						th Check only o			
5	Phys this ral dir	To	1 Yes 2 No	ospital: 1 ☐ Inpatien 28a. Date of Injury	2 ER/Outpat	-			ome 5 Resid			y)
200	r Attending I er death. rector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day	Year) Injur	M		es 2 No	28d. Describe h			
2	oital or A urs after oral Directilled in by		4 Homicide determined	28e. Place of Injur building, etc.	(Specify)				City or Tow	vn, State)		ul Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medicai	29a. Certifier (Crock only one)	ician: To the best of er: On the basis of a and manner state	xamination and/or	investigat	tion, in my opi	nion, death occu	, and due to the or rred at the time, or	cause(s) and date and plac	manner as si e, and due to	tated. o the cause(s)
	To With	Σ	29b. Signature and title of certifier				29c. License		I	29d. Date sig		
	DXI	1	Daws 55	-			03	2295		Age:)	4,20	200
	137		30. Name and address of person who con	N 6.56	u macth	1.1	Relo	or me	).			
	Sta Registra	- 1	31. Date filed (Month, Day, Year) APR 0 5 21	32. Hagistrar	s Signature	Loon	E)					

State of Maryland / Department of Health and Mental Hygiene: Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 10 Clara E. Michael March 31 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner and Rehabilitation CHBel Air Del Air Health Harford 8. Date of Birth (Month, Day, You Oct. 27, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F Days Hours Year. Director 91 Maryland 213-16-6848 1914 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow rthen "natural", or items 23a or 28a-f ehov tra Medical Examinar must be notified at Md. Baltimore White Marsh 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11540 Philadelphia Road 21162 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No white þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) 3 years homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event 9DGE. Michael J. Gross Emma V. Burgman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Fritz/daughter 4528 Oak Ridge Drive, Street, MD 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State t ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gdns. 4/5/06 Timonium, Md. 21. Signature of Fulleral Service Licenses 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Peath Physician neumonic bou /Medical (or as a consequence of) Weeks Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy been signed by the atte should be detached for Month Year Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan has 1 ☐ Yes 1 Yes 2 - NO 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 2 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number h completed suse of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Ye APR 0 Year) State 2006 5 Registrar

	1 - For State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of State of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department of Maryland / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Department / Departm	artment of Health and Martificate of Death		ene))6	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
sician	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
edical	PHILIP EMRY MAPES		March	26, 2006	2:55 p M
miner	4a. Facility Name (If not institution, give street and number) 6115 Brooklyn Bridge Road	4b. City, Town, or Location of Death Laurel		4c. County of Deat	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince G	hplace (State or Foreign
ral tor	1449-22-06/5 12M 2 F 74 Yrs.	Months Days Hours Min.	(Month, Day,	Year) 1931 Nor	th Dakota
	Usual Residence of Decedent		MAY 18	1121	
	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
cto	MD Prince George's Laurel				1 Tes 2 No
Funeral Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?
erai	6115 Brooklyn Bridge Road  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20707 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	U.S.A.	rican Indian
듄	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1954	1 ☐ Yes 2√☐XNo Specify:		Specify: W.	hite
Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 10	6b. Kind of Business/	Industry
idu	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of work DO NOT use retired)			
ပိ	2 Years Supe	rvisor	e (First, Middle, Mi	PEPCO	
Be	Emry Mapes	Grace E		araon comano,	
2		ng Address (Street and Number or Run		City or Town, State, 2	Tip Code)
		Brooklyn Bridge I		rel, Mary	
	20a. Method of Disposition 20b. Place of Dispo			0c. Location - City or	
			/2006 R	Rockville,	Maryland
once.  To Be Completed by Funeral Director	21. Signature of Funeral Service Lo nsee	2. Name and Address of Facility Donaldson Funeral	Home. P.	Δ	
9	Janue Dansedich M00160	313 Talbott Avenue	Laurel	, Marylan	1 20707
dicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of ir lu.) that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	CER			Onset and Death
ieted by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
by P	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		acco use contribute to	. /
ted			1 Tes	3 2 □ No 3 □ Pr	obably 4 Munknown
Comp				ed? prior to death? No 1 Yes	topsy findings available completion of cause of 2 X No
o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 EP/Outpatier	Other	h <i>(Check only one,</i> ome — Residen	nce 6 ⊡Other (Spe	cifu)
I	27. Manner of Death    Salar of Injury   28b. Time of Injury   28b. Time of Injury   28c. Accident   28c. Accident   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of Injury   28c. Time of In		28d. Describe how		ary)
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	Iral Route Number,
Medical Cert	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occur	red at the time, dat	te and place, and due	to the cause(s)
3	29b. Signature and title of chiffier	29c. License number	290	d. Date signed (Manti	Day, Year)
1	Cert . I worken	10006313	1	2/28/0	00
	30. Name and address of person who completed cause of death (Item 23a) (Type, AKIL MERCHANT, 401 N. BROADWAL	1, BALTIMORE	MD	21231	
State		asile			
1	AKIL MÉRCHANT, 401 N. BROADWAL		MD	3/28/C 21231	)6

		1 - For State Ragistrar	State of Maryla		artment of rtificate o		Mental Hygie	2000	104.85
Physic /Med Exam	ical	1. Decedent's Name (First, Middle, Last  Northaniel  4a. Facility Name (If not institution, give	G. MCK	7ight	4h City Town	, or Location of Dea	04	Day Year Zoo 4c. County of Death	
Funera Directo		ZII3 Tucker  5. Social Security Number 6. Se	Lane Ap	Bl . last birthday) Yrs.	GWYNIN  If Under 1 Yes  Months Day	JOAK	s. 8. Date of Birth	BALTIMORE	place (State or Foreign
ne Maryland 8a-t ehow	Director	Usual Residence of Decedent  10a. State 10b. County  M D BALTO.		ity, Town or Lo					10d. Inside City Limits 1 Yes 2 4No
and 21215-0036  be filed within 72 hours after death with the Maryland ntat Hygiene. Id other than "natural", or items 23s or 28s-1 show event, it a Madical Examinat must be redified at	Funeral Dire	2113 Tucker L  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in (Armed Forces?	3) J.S.   13. Y		1207 Hispanic Origin? (Idan, Mexican, Pue		Citizen of What Cour USA  14. Race - Americ Black, White,	can Indian,
215-0036 hin 72 hours at in "natural", or Mudical Exam	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade) Elementary/Secondary (0-12)	If Yes, Give Year or Dates: cation e <i>completed)</i>	16a. Deced	lent's Usual Occ kind of work dor OO NOT use reti	upation	orking 16b	Specify: 6)  Kind of Business/In	•
be filed ital Hygi of other	To Be Com	17. Father's Name (First, Middle, Last)	College (1-4or 5+) N A	L	ong.	Shoven 18. Mother's Na Lolo	me (First, Middle, Maid		Front
C = 01 L		19a. Informant's ame/Relationship (Ty Catherine Hawk	pe, Print)			et and Number or R	ural Route Number, Cit	ty or Town, State, Zip	
Page nent o		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Place of Dispos	sition (Name of		Date 20c.	. Location - City or To	own, State
p mit. Par Depurtment In portant: • y njury o		21. Signatur of Funeral Service License		22. <b>5</b> 1	Name and Add	ress of Facility Va	ughn a G	Batta Pr	Meral See.
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To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely illed in by the funeral director.	Certification: To E	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide	ospital: 1 Inpatient 2 Inpatient 2 Sea. Date of Injury (Month, Day Year)  28e. Place of Injury - At he building, etc. (Specifications)	28b. Time of Injury	28c, Inju	her: 4 Nursing H		and Number or Rural	
Hospital 24 hours a Funeral	Medical Ce	29a. Certifier (Check only one)	ician: To the best of my kno	wledge, death tion and/or inve	occurred at the t	me, date and place	, and due to the cause rred at the time, date a	(s) and manner as st nd place, and due to	ifed the cause(s)
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Sta		30. Name and address of person who con Debra	npleted cause of death (Item	700 8	Securi	y Blud	. , Bulto	nd z	1244
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Examir Funeral			-	4b. City, Town, or Location of Death  BOY T MOFE  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	4c. County of Death	n nplace (State or Foreign untry)
Director		220-30-5159 1 €M 2 ☐ F Usual Residence of Decedent	70 Yrs.			35 MAX	RYLAND
a-f ehow	ctor	10a. State 10b. County  AD ANNE ARUNDE	10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 No
h with the	ai Dire	10e, Street and Number 5406 BAILMAN AVE		10f. Zip Code 2\2\2\5	10g. (	Citizen of What Cou	intry?
72 hours after death with the Maryland natural; or iteme 23a or 28a-f ehow diest Examinations! be rediffed at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marned  3 □ Widowed 4 ☑ Divorced  1 □ Yes 2 If Yes, Give Year or Date	₩o	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	ican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mantal Hygiens. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f ehow enty injury or other treumatic event, the Madical Examinational De notified at any lower.	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4	16a. Dece (Give	dent's Usual Occupation skind of work done during most of work DO NOT use retired)	ing 16b.	. Kind of Business/li	
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and 2 should leetth and Men m 27 is marke		19a. (Informant's Name/Relationship (Type, Print) VRYINIA MILITA, NIECE	19b. Maili	ing Address (Street and Number or Rur	OKYNAK.M	M. ZIZ	25
nit. Pages 1 ertment of H ortant: If Ite injury or ot a.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Germation 3 ☐ Removal from St.  4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Figural Service Liceusee	ANATOMY C	ostition (Name of matory or other place)  ATT PERISTRY 4-4  2. Name and oddress of Facility	Date 20c.	Location - City or T	own, State
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To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  1  Namer of Death 1  Autural 5  Pending		nt 3 DOA Other: 4 Nursing Ho	h Check only one one one 5 Residence 28d. Describe how in		rfy)
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he Hospitt in 24 hours he Funere pletely fille	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the base and manner	s of examination and/or in	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
Mithi To t	Σ	29b. Signature and title of certifier	an mp	29c. License number	29d. I	Date signed (Month	, Day, Year)
2		30. Name and address of person who completed cause	of death (Item 23a) (Type,	Print) HAWOVER ST., 8	AL TIMOR	MAN	e/Lano
Sta Registi			istrar's Signature		1100		

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			For State Registrar								Death			Reg. N	ia.	10	104	81
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Fum	orol		13938 Layhill  5. Social Security Number	6. Sex		7. Age (In y	yrs. last birtl	hday)	If Under	1 Year	If Unde	r 24 Hrs.	8. Date of Bir (Month, Da	e bo			nplace (State	or Foreign
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	111		> KUHER	<i>√</i>		/			7	000	350	43		1114	PRCH	28)	2006	)
			30. Name and address of parson	who comple	eted cau	se of death	(Item 23a) (	Type, Pr	rint)	Pi	10-	Da.	15 # Zar	1	אות ול	y W	in 70	832
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tal Rec		Be Completed	25. Was case referred to medical						26 Place	of Death	24a. Was a autop perfor 1 Yes	sy me <b>s</b> t? 2 □ No	pr	or to cor	psy findings available inpletion of cause of ZEI No
Division of Vital Records,	ng Phy fter this neral d	Certification: To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be determined	e 28e. Place of I	njury Day Year) Injury - At ho	ER/Outpatient 28b. Time of Injury	M 28	3c. Injury Work 1 🗆 Y	r: 4 🗆 Nui	rsing Hor	ne 5 Resid	ence 6 ow injury	occurre	d	/)  I Route Number.
ດັ້	Hospital or 4 hours afte Funeral Dir ely filled in	Medical Cert	29a. Certifier 1 Certifying Ph	ysician: To the be	of examina	wledge death	occurred a	t the time	e, date and	d place, a	City or Tow	21150/5)	and man	ner as st	ated. the cause(s)
•	To the To the complet	Med	29b Signature and title of certifier	and manner	stated.		29c.	License			ż	29d. Date		(Month, i	Day, Year)
2	1		30. Name and address of person who	RKCALDY	- 18	101 P	Print)	E PH							
	Sta Registr	-	31. Date filed (Month, Day, Year) APR 0 5	2006 32. R	strar's Signa		parte	p							

State of	of Maryland / Department of Health and
rar	Certificate of Death
's Name (First, Middle, Last)	
D ETCHED MODDISON	

		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	partment of I e <i>rtificate of</i>		Mental Hy	giene (	) 0 6	10489	
		Decedent's Name (First, Middle, L.	ast)				2. Date of De	aath		3. Time of Death	
Physicia /Medic		ESTHER FISHER MORE	RISON				april	Say	2006	9:15 AN	
Examin		4a. Facility Name (If not institution, g Roland Park Place	ive street and number)		4b. City, Town, Baltimore	or Location of Death	1	4c. Co N/	unty of Death		
Funeral Director		224-16-0408	Sex 7. Ago 1□ M XXXF 89	e (In yrs. last birthda Yrs.	y) If Under 1 Year Months Days		June 2,	1916	9. Birthe Coul West	olace (State or Foreig otry) Virginia	
pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				1	10d. Inside City Limits	
e Maryli 3a-f eho	Director	Maryland N/A		Baltimore						XX Yes 2 □ No	
after death with the Maryland or items 23a or 28s-f ehow priver must be notified at	al Dire	10e. Street and Number 830 West 40th Street			10f. Zip Code 2121	1			of Whal Coul JSA	ntry?	
	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13	B. Was Decedent of	Hispanic Origin? (Si pan, Mexican, Puert	pecify Yes or N	0- 14.	Race - Americ Black, White,		
	by	1 ☐ Never Married 2 ☐ Married	Amed Forces?  1  Yes 2 XX	40	1 ☐ Yes 2 <b>X</b> XNo		o t noar, oto.,	1	ecify: Whi		
in 72 hours n "naturel", dedical Exa	Completed	15. Decedent's (Specify only highest g	rade completed)	(Giv	cedent's Usual Occu ve kind of work done . DO NOT use retire	during most of work	king	16b. Kind	of Business/In	dustry	
d with	E	Elementary/Secondary (0-12)	College (1-4or 5 4	+)	Nurse			5	School		
ald be filed fental Hygirked other itic event, I	o Be C	17. Father's Name (First, Middle, Las Ashby Fisher	et)			18. Mother's Nam Mamie E	, .	, Maiden Sui	mame)		
nd 2 should lth and Mer 27 ie marke traumatic		19a. Informant's Name/Relationship Lynn M Venetoulis		OTR 24 WO	iling Address <i>(Stree</i> Odward Lane	t and Number or Ru Lutherville	ral Route Numb e, Marylai	nd 21093	own, State, Zip	Code)	
s 1 ar f Hea item i		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other pla	aca)	Date	20c. Locati	ion - City or To	own, State	
permit. Pages 1 and 2 should be flied within Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatic event, the Magnes.  To Be Compl		1 ☐ Burial 2 <b>XX</b> Cremation 3 _4 ☐ Donation 5 ☐ Other (Spec		GreenMount		4/4/0	06	Bal	ltimore,	Maryland	
permit. Depertrimports eny inju		2/ Signature of Funeral Segrica Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funera 6500 York Road Baltimore, M									
		23a. Part1. Enter the disease, or co- shock, or heart failure. List only	y one cause on each lir	10.		ing, such as cardiac	or respiratory a	rrest,		Approximate Interval Between	
Physician <sup>1</sup> /Medical	4	tmmediate Cause (Finat disease or condition resulting in death)	, a. Vasen	ear des	neation	)				9nset and Death	
Examiner			Due to (or as	a consequence of):	Cardin	i vascula	AL RO		Years		
1	er	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):							
cuted nd ransit	Examiner	that initiated events	C.								
licate be executed physicien and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as	a consequence of):							
ath certing attending for use a			d								
		IF FEMALE: 23b. Was decedent pregrant in the past 12 manths? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							. Date of delive Month	ery Day Year	
law requires that the de as been signed by the a 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
need s	eted	1 Yes 2 No 3 Probably									
	Completed								4b. Were auto prior to co death? 1 \( \sum \) Yes	psy findings available inpletion of cause of 2 No	
icien: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Qea	th (Check only	one)			
Physi this c al dire	_C	1 ☐ Yes 2 ☑ No	Hospitat: 1 Inpatie		ent 3L DOA		ome 5 Res			(v)	
Attending Physicien: r death. ector: After this certific by the funeral director.	atlon	27. Manner of Death  1 Naturat 5 Pending 2 Accident investigati		y Year) 28b. Time Injury	Wo	iry at ork? ]Yes 2 □ No	28d. Describe	now injury of	ccurred		
i Dift o	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, farm, s c. (Specify)	street, factory, office			Street and N wn, State)	umber or Aura	al Route Number,	
Hospital 4 hours Funeral tely filled	ical (	29a. Certifier 1 ✓ Certifying F (Check only 2 ☐ Medical Ex	hysician: To the best of	of my knowledge, de examination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occu	ne cause(s) and manner as stated. e, date and place, and due to the cause(s)				

State Registrar

31. Date filed (Month, Day, Year)

APR 0 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. GABELLE THEYREGOR, 700 W. 40th STREET, BALTIVARE, 070 2/2/1

29b. Signature and title of certifier

M. Trabelee

29c. License number

D13657

29d. Date signed (Month, Day, Year)

- Walley	Phy /N Exa	/sician ledical aminer	er
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner

		1 - For Stata Registrer	State	of Maryland		artment of F		and Me	_	giene leg. No.	Ü	0490
Physic /Medi		Decedent's Name (First, Middle LTLLIA		NORWIG	ì				2. Date of Dea Month	Day	Year	3. Time of Death 4:35 p M
Exami		4a. Facility Name (If not instituti	on, give street and n	umber)		4b. City, Town, o	_	f Death		4c. County		
		7-1-1-	<del></del>	Mezical a		Glen	Bur			ANN	e A	woode/
Funeral Director		5. Social Security Number 212-09-2356	6. Sex 1 □ M 2 Ø F	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under: Hours	Min.	8. Date of Birth (Month, Day June 01	,1915	9. Birthp Coun Mar	lace (State or Foreign try) y Land
laryland show		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, To	own or Loc	cation					1	0d. Inside City Limits
Man B-f sh	tor	Maryland Ann	e Arundel	Ba1	timo	re						1 ☐ Yes 2 No
ith the M or 28e-f	Director	10e. Street and Number			-	10f. Zip Code			1	log. Citizen of	What Coun	try?
ath w s 23e		5613 Cliffsid				2122	25			U.S.	Α.	
filed within 72 hours after death with the Maryland Hygiene. Hygiene, the than "natural", or items 23e or 28e-f show ant. It e Macited Examinational Court Countille 1 at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	rried 1 ☐ Yes	2 <b>IZ</b> No iive		Vas Decedent of H Yes, specify Cuba	ispanic Orig in, Mexican Specify:	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)	Blac	ce - Americ ck, White, Whit	etc.
ithin 72 hours he. han "natural"	Completed		nt's Education est grade completed College	(1-4or 5+)	(Give I	ent's Usual Occup- kind of work done of OO NOT use retired	ation during most ()	of workin	g	16b. Kind of B	usiness/Inc	lustry
iled w tygier her th		17. Father's Name (First, Middle	0		Hous	sewife				Ноп		
uld be fi Mental H arked ot	To Be		Strauss					ine line	(First, Middle, ) H	<sup>Maiden Suman</sup> ertzber		
2 sho and is ma		19a. Informant's Name/Relation				g Address (Street a						
1 and Health em 27 ther t		Lillian M. Sa 20a. Method of Disposition	lvatore (	Daughter)		Riverton	Plac	e, Ed				
ages ant of t: If it		1 Burial 2 Cremation		State Ceda	tery crem	atory or other place	e) 0	4-04-		20c. Location - Baltimo		wn, State faryland
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than "na any injury or other treumatic event. It a Macali once.		' 4 □ Donation 5 □ Other ( 21. Signature of Funeral/Service		.//		Name and Address Cully-Po 37 East P						
170		23a Janti Enter the disease, of shock, or heart failure. Lis	complications that	caused the death. D								Approximate
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	_ a. A3	or as a consequence	o P	NOUMON						Interval Between Onset and Death
P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Under in	b. Due to	(or as a consequence	e of):							
cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a consequenc	e of):				-			
icate be physicia s the bu	dical		d							<del></del>		
or Attending Physicien: The law requires that the death certiff stee death. Director: Atter this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1 Live	itcome of pregnancy birth 2 ☐ Fetal dea nant at time of death nown		Ectopic pregnancy Other (specify)			- 120H2	23d. Dat Mod	e of deliver	y Day Year
w requires that the death been signed by the atte should be detached for	by	Part II. Other significant conditi	ons contributing to o	leath but not resulting	in the und	derlying cause give	n in Part I.		23e. Did tob			e cause of death?
ysicien: The law re is certificate has be director, page 2 sho	Completed							_	24a. Was ar autopsy perform	y p	rior to com leath?	sy findings available pletion of cause of
sicien: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospitali			Otho			Check only one			
Phys	To To	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 ER/C	Outpatient  Time of	3 DOA	4 Nur		5 Reside			
nding th. :: Afte e fune	atlor	1 Natural 5 ☐ Pendi		th, Day Year)	Injury	28c. Injury Work M 1 □ Y	? ′es 2 □ N		d. Describe no	w injury occurr	90	
or Atte after des Director	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Place	e of Injury - At home, ing, etc. (Specify)	farm, stree	et, factory, office		28	f. Location (Str City or Town,	reet and Number, State)	er or Rural	Route Number,
To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director; After this completely filled in by the funeral di	edical	29a. Certifier	exeminer: On the p	e best of my knowledge basis of examination a liner stated.	ge, death o	occurred at the time estigation, in my op	e, date and inion, death	place, and	d due to the ca at the time, da	use(s) and mar ite and place, a	nner as sta	ted. the cause(s)
	Σ	29b. Signature and title of certific Hen 7	nom W	,		Do2		5		April 2		
10	- 4	30. Name and address of person	notridan	Hospital	Me	scal Ce	ater	, 6	ler E	Burrio	-	
Sta Registra		31. Date filed (Month, Day, Year, APR 0	5 2006	gistrar's Signature	Ma	who .						

			1 - For State Registrar		Marylar	_	artmer rtificat			nd M		Reg. No.			104	91
	Physici	3n	Decedent's Name (First, Middle, Last,								2. Date of Dea Month	ath Day	Y	ear	3. Time o	
	/Medic		Mary McHale Newhou								March	31,	20		8:55	P. <sup>M</sup> .
	Examin	er	4a. Facility Name (If not institution, give	street and nun	iber)			Town, or	Location of	Death			County of I		0.237	
			Brighton Gardens  5. Social Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Security Number 6. Secu	·	7. Age (In yrs.	last hirthday)		r 1 Year	if Under 2	4 Hrs.	8. Date of Birt				lace (State	or Foreign
	Funeral Director			M 223F	97	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	08	Coun	York	or r oreign
	ס		Usual Residence of Decedent		140- 0											
	within 72 hours after death with the Maryland ene. Than "naturel", or items 23a or 28e-f ehow he Madical Exeminer rount by motillind at	5	10a. State 10b. County  Maryland Montgon	erv		ty, Town or Lo Bethesd								1	0d. Inside C 1 □ Yes	s 2 🖾 No
	28e-f	ecto	10e. Street and Number					Code				10g. Citiz	an of Wha	t Cour		
	with Ba or	Funeral Director	4949 Battery Lane,	Aparti	nent 11	12		0814					ed S		-	
	death	era	11. Marital Status	12. Was Dece	dent Ever in U		Was Dece	dent of Hi	spanic Orig	in? (Spe	cify Yes or No- Rican, etc.)	- 1.	4. Race -			
ဖွ	or its	Fu	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Giv	2⊠No	1	irres, spe 1 ☐ Yes		Specify:	Pueno	Hican, etc.)	1	Black, 1 Specify:			
8	ure!',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Da	ites:						- ··					
7	n 72	Completed	15. Decedent's Edu (Specify only highest grad			16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa ork done d ise retired	ition <i>Juring most</i> )	of workir	ng	16b. Kin	d of Busin	ess/inc	lustry	
12	withi iene. then	E O	Elementary/Secondary (0-12)	College (1	-4or 5+)	Homem		,				Ow	n Ho	ne		
ק	othe	BeC	17. Father's Name (First, Middle, Last)								(First, Middle,		iumame)			
/lar	Venta Wenta Irked Itlc e	ToE	Martin McHale						Mar	y (ı	ınknown	)				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Instruction: If Item 27 is marked other than "naturel; or Items 23a or 28e-f show eny injury or other traumatic event, the Madical Examiner cust be notified at QDGs.		19a. Informant's Name/Relationship (Ty		Son	19b. Mailie	Nov+1	(Street a	nd Number	r or Rura	Apt.	er, City or	Town, Sta	te, Zip	Code)	MD
é)	l and lealth om 27 sher ti	Į į	Martin McHale Newh	iouse /		Place of Dispo			K AVE		ate		ation - Cit			° 20815
altimore,	nt of h		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F		State	cemetery, crei	matory or t	other place	1 A	pri1	8,				wii, state g, Marj	v1 and
==	iit. Partmer artant njury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens			e of Hea			0	2006	,		_	-		-
Ba	Dept Impo				< MO1	1433 Be	thes	la-Cl	evy C	hase	ert A. 0814-3	7557	Wis	con	sin A	venue
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that ca	used the deat										Approxima Interval Be	ite
	Pnysician :		Immediate Cause (Final disease or condition		roscle:	rotic H	leart	Dise	ase						Onset and Years	Death
	/Medical		resulting in death)	a	or as a consec									1		
	Examiner	_		b	or as a our sec											
V	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D09 10 (-	or as a consec	(transcarut):										
Υ	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (	or as a consec	quence of):										
,097	ite be executed iysician and he burial-transit	cail		d												
89		_	In the second of													
.О. Вох	death certifica e attending ph id for use es th	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outo	come of pregnanth 2 Feta		∃Ectopic p	regnancy				23	d. Date o	f delive	•	Year
		Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4⊟Pregna 9⊟ Unkno	ant at time of o wn	death 5	Other (s	pecify)					MOHEN		⊔ay	real
Δ.	requires that the de een signed by the a hould be detached i	Ph	Part II. Other significant conditions con	ntributina to de	ath but not res	sulting in the u	nderlying	ause dive	n in Part I.		23e. Did to	obacco us	e contribu	te to th	e cause of	death?
Records,	8 6 8	d by	Rectal Cancer			•	, ,	•			101	/es 2□	No 3[	Prob	ably 4 🔼	Unknown
Ö		iete									24a. Was	an	24b. Wer	e autor	osy findings	available
He H	The law ate has b page 2 s	Completed									autop	rmed?	prio dea	r to cor th?	npletion of a	cause of
ta	nysicien: The law his certificate has l director, page 2 s	Be C	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		1 🗆	Yes	2□ No	
<u>=</u>	Physicien: rthis certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🗆 Ir	patient 2	ER/Outpatier	nt 3 D	Othe Othe	M**		ne 5 Resid		□Other (	Specify	')	
Division of Vital	<u>a</u> = e		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date o (Monti	f Injury n, Day Year)	28b. Time of Injury	f	28c. Injury Work	at ?	2	28d. Describe h	now injury	occurred			
Sio	Attending ir death. sctor: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				М		fes 2□N							
$\leq$	i 를 들 드	Certification:	4 Homicide determined	28e. Place buildir	of Injury - At h ig, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factor	y, office		2	28f. Location (S City or Tox		Number o	r Rura	Route Nun	nber,
_	To the Hospital within 24 hours a To the Funerei I completely filled		29a. Certifier 1⊠ Certifying Phy	sician: To the	best of my kno	owledge, deat	h occurren	at the tim	e, date and	place. a	and due to the	cause(s) a	nd manne	er as et	ated.	
	ne Hoo	ledicai	(Check only 2 Medical Exami one)	ner: On the ba and mann	sis of examina	ation and/or in	vestigation	n, in my op	inion, death	n occurre	ed at the time,	date and p	lace, and	due to	the cause(	s)
	To the withing To the Comp	Me	29b. Signature and title of certifier	1 1				c. License				29d. Date	signed (A	fonth, l	Day, Year)	
	2		/suf-	12 20		jar	D	33357	/			Apri	1 3	, 2	006	
	V		30. Name and address of person who co Lee Jonathan Mush	ompleted cause	of death (Iter	m 23a) (Type,	Print)	venu	. #10	145	Chevy	Chass	Ma	rv1	and 2	0815-
	-6								, If I	,,,	onevy	Juas	, 110	- y 1	L	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5 20	06	en ,	& A	de	,								

			1 - For State Registrar	State of Ma	ryland /		artment <i>tificate</i>			and M		jiene jeg. No.	06	10492
4	75e		1. Decedent's Name (First, Middle, Las								2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		SAM D. O'BRIAI	UT , JR.							APRIL	3	2006	1:00 A M
	Examir	er	4a. Facility Name (If not institution, give	MAL				TIMO	KE				N/A	
alt.	Funeral Director		5. Social Security Number 6. S  243 · Lo8 · 1974  Usual Residence of Decedent	ex 7.'Age	(In yrs. last t	Yrs.	ff Under 1 Months	Days	Hours	Min.	8. Date of Birth (Month, Day 05 · 05	, Year)	Coui	NC
	yland		10a. State 10b. County		10c. City, To	wn or Lo	cation					-	1	Od. Inside City Limits
	a-f at	tor	MD BALTIMO	RE	CATON	IVEL	LE							1 ☐ Yes 2 🔀 No
	or 28	)ire	10e. Street and Number				10f. Zip (					10g. Citizen o		ntry?
	ath w	rai	5910 ROBINDALE 1			1.21		1228		. 0.10	* N = 1	14.5	USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or itema 23e or 28e-f ahow appring or other traumatic event, the Medical Exercitational Decoding a page.	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:		"	Vas Decede Yes, speci	fy Cuban	Specify:	gin? (Spe i, Puerto I	icify Yes or No- Rican, etc.)		lace - Americ lack, White, cify: BLAC	etc.
-00	2 hou	ted	15. Decedent's Ed	ducation	16	a. Deced	lent's Usual	Occupat	tion	t of condition		16b. Kind of		
215	ithin 7 18.	Completed	(Specify only highest gra	de completed) College (1-4or 5	<b>+</b> )	life. L	kind of work	e retired)	iring most	or workir		1	Im 4 Oo	011-01-01-01-01-01-01-01-01-01-01-01-01-
21	filed wi Hygien other th		11 TH GRADE	N A		CAIR	PENTE		10 Matha	r'a Namo	(First, Middle,		-	OVEMENT
Maryland 21215-0036	should be fi ind Mental H marked of umatic ever	To Be	SAM D. O'BRIANT	SR.					ROSIE	: N	MAE WI	LEY		
Mai	d 2 sh th and 7 la n traun		19a. Informant's Name/Relationship (	1	\		ROBIN				I Route Numbe ATONSVI			71 <b>22</b> 8
ē,	tem 27		20a. Method of Disposition	idi (vair 2	20b. Place	of Dispo	sition (Nami	e of		, D	ate	20c. Location		own, State
mo	Pages nent of I ant: If It		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		KING	PAR	natory or oth	ner piace		4.08	.06	ZANIDAL	18TONI	M. MD
Baltimore,	permit. Depertm Importa any inju		21. Signature of Funeral Service Licen	isee ]	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	VÃ	Name and	Address C · G 10. N	of Facility	Fun	JERAL SI BAUO. N	ERVICE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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10 mg	Examiner				CONSEQUENCE	B 01).				*				
8760,	icate be executed physician and si the burial-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the order of the cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as a										
687	tificate ng physi as the	edicai		d										
.O. Box	death cer e attendir id for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of the little birth 4 □ Pregnant at 9 □ Unknown	Fetal deal		Ectopic pre Other (spe						Date of delive Month	ery Day Year
S, D	The law requires that the de ste hes been signed by the a page 2 should be detached f	Ď	Part II. Other significant conditions of SEVEVEL ACKTIC	ontributing to death bu	t not resulting	in the ur	nderlying ca	use giver	n in Part I.			bacco use co es 2 □ No		ne cause of death?
Vital Record	s been si should	Completed	DIABETES MELLIT	us							24a. Wasa	n 24t	D. Were auto	psy findings available mpletion of cause of
æ	: The taw cete hes page 2:	mo:	END STAGE REN	AL DISEASE	:						autops perfor	med? 2 No	death?	
ita		Bec	25. Was case referred to medical examiner?						26. Place	of Death	Check only or			
of <	Q & D	၉	1 Yes 2 No	Hospital: 1 Inpatie		utpatien				rsing Hon	ne 5 🗆 Resid	ence 6 □C	ther (Specif	y)
Division o	Attending Pir death. ector: After tiby the funera	Certification:	27. Manner of Death 1  Avatural 5  Pending 2  Accident investigation		Year) 28b.	Time of Injury	м 28	Work	at es 2 🔲 l		28d. Describe h	ow injury occ	urred	
É	ital or Att rs after d al Direct led in by i	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Inju building, etc	ry - At home, (Specify)	farm, stre	eet, factory,	office		2	28f. Location (S City or Town		mber or Rura	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai		ysicien: To the best of niner: On the basis of and manner sta	examination a						ed at the time, d	ate and place	e, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	P				License				9d. Date sign		
,	1		marin Carme	in n. Broat	a, MD			P180	614		/	APPCIL	3,200	6
	5		30. Name and address of person who waiking income and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of person who waiting the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same and address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same addre	S CATON	AUE E	SALTIL	MOKE,	мо	2122	9				
* * * * * * * * *	Sta Registr		31. Date filed (Month, Day, Year)  APR • 5 200	Registra	r's Signature	Since of								

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			For State Registrar	State o	f Mary			rtment of H				giene Reg. No	UUI	)	and section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the section of the se	93
			1. Decedent's Name (First, Middle, L	ast)				-			2. Date of De Month	Da	v	Year	3. Time of	f Death
	Physicia /Medic		Louise M. Odel	1							March 3	31,	2006		12:15	PM <sup>M</sup>
	Examin		4a. Facility Name (If not institution, g					4b. City, Town, or				40	. County o			
			Broadmead Ret				7- 1	Cockeys	ville If Under		0 Data of Rid		Balt			or Cornina
	Funeral Director		5. Social Security Number 6. 092-20-6070	Sex 1 ☐ M 2 🛱 F		n yrs. last birthi 81 Yr		Months Days	Hours	Min.	8. Date of Bird (Month, Da Mar 14,	y Year,	25	Cour	olace (State o otry) York	or Foreign
			Usual Residence of Decedent			<u> </u>				1 ř						
	nyland how		10a. State 10b. County		10	Oc. City, Town								1	0d. Inside C	
	ith the Marylar or 28a-f ehow	ctor	MD Baltimo	re		Cocke	ysv									2X No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Departments of Heath and Mental Hygiene. Importents: If time 27 le marked other than "natural; or items 23s or 28s-1 show any injury or other traumatic event, the Madical Examiner rust by multified a page.	al Director	10e. Street and Number 13801 York Road					10f. Zip Code 21	030			10g. Ci	tizen of W US		itry?	
	death	Funeral	11. Marital Status	12. Was Dec		or in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Or	igin? (Spe n. Puerto l	ecify Yes or No Rican, etc.)	)-		- Americ	an Indian, etc.	
98	s after		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ②Divorced		2 X No ve			☐Yes 2¶ No	Specify:					whit		
9	2 hour	Completed by	15. Decedent's	Education	,a103.	16a. D	eced	ent's Usual Occupa	ation			16b. F	Cind of Bus	siness/In	dustry	unk
7.	nin 72 nin "ne Medik	plet	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (	1-4or 5+)		Give k life. D	ind of work done of O NOT use retired	turing mos )	st of workii	ng					
21.0	giene giene gr tha	Som	12	5+		s	oc	ial worke								
7	tal Hy d oth	Be	17. Father's Name (First, Middle, La								(First, Middle,		n Sumame	9)		
2	Meni Meni Marke hatic	10	Harold John Mi			-		Address (Street a		<u> </u>	Pinkh			24-4- 7	- 0 - 4 - 1	
1	d 2 sh h and 7 le m traum		John L. Ode11/s					Harcourt				-	212		Code)	
9	tem 2		20a. Method of Disposition			20b. Place of D	Dispos		-		ate		ocation - (	City or To	own, State	
2	Pages net of nt: If i		1 ☐ Burial 2 ☐ Cremation 3  1 ☐ Surial 2 ☐ Cremation 3		State	Centerery	CIGIII	atory or ourer prac								
Raltimore Maryland 21215-0036	permit. Departm Importe any inju		21. Signature of Funeral Service Lice	wad,	178	tor	-	Name and Addres tate Anat				. Ва	altim	ore	Street	t
		_	23a. Part I Enter the disease for co shock or heart failure. List or	mplications that	caused the	e death. Do no	t ente	altimore, or the mode of dyin	MD g, such as	2120 cardiac o	r respiratory a	rrest,			Approxima Interval Be	te
	Pnysician		Immediate Cause (Final	ly one cause on	each line.	1151		Trans	n 1/4	Lin					Onset and	Death
	/Medical		disease or condition resulting in death)	a. Due to	(or as a c	onsequence of	):	1000	1/1	4/0						
74	Examiner		Sequentially list conditions	b	TYL	mte	m	5490								
2	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury													
12:15pm	xecute and Il-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
%/ 03780	cate be executed physician and the burial-transit	dlcal E		d												
10 G	certificat nding phy use as th	ledi														
1/0	th cer tendir	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		birth 2 [	Fetal death		Ectopic pregnancy					23d. Date Mor		-	Year
13/	. 5 . 5	by Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Preg 9⊡Unkr		ne of death	5 🗌	Other (specify)								
W. O	The law requires that the law sequires that the law sequires that the lab has been signed by the lagge 2 should be detache	y Ph	Part II. Other significant condition	s contributing to	leath but r	not resulting in	the un	derlying cause giv	en in Part	I.	23e. Did 1	tobacco	use contr	ibute to t	e cause of	death?
Š	quires an sign										10	Yes 2	2 □ No	3 Prol	bably 4 🗆	]Unknown
of Vital Becords	aw re	Completed									24a. Was		24b. V	Vere auto	opsy findings	available cause of
13 0		Com									perfo	ormed?	d	eath?	2□ No	
43	sician: The law certificate has birector, page 2.5	Be	25. Was case referred to medical examiner?	Hamilad				0.4		e of Death	(Check only	one)				
2	Physic this c	2	1 Yes 2 No		Inpatient	1.7	_		4 P N		me 5 Resi 28d. Describe	_	_	, ,	(y)	
	Attending Physician: r death. ector: Atter this certific by the funeral director.	tlon	27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date (Mor	nth, Day Y	/ear) Zob. In	ury	28c. Injun Wor M 1 🗆	k? Yes 2.⊑		20d. Describe	11044 11131	ary occurr	<b>5u</b>		
tal (	l or Attendiater death.  Director: A lin by the fu	flca	3 ☐ Suicide 6 ☐ Could no	t be 28e. Plac	e of Injury	At home, farr	n, stre	et, factory, office			28f. Location (			er or Run	al Route Nur	mber,
2 6	s after	Certification;	4 Homicide	build	ting, etc. (	(Ѕреспу)					City or To	Sta				
Lewise	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (		eminer: On the i		kamination and		occurred at the tin restigation, in my o								(s)
10	To the within To the comple	Me	29b. Signature and title of certifier			11.	~	29c. Licens	e number			29d. D	ate signed	(Month,	Day, Year)	
			Parla	ra W	CV	roll.	//)	D	38	39	2		3/3	3//	200	6
			30. Name and address of person w	no completed cau	ise of deal	th (Item 232)	уре,	Print)	771	1/	nd.	Pal	1 (	clo	1.12.11	11, 10
	Sta	ato.	31. Date filed (Month, Day, Year)	32.	/\(\)/ Registrar's	s Signature	1	N., 13	801	70		14	10	The	you	IW/1/
	Regist		APR 0 5 200	6 Secret	a K	s Signature	ME	<i>)</i>								

		1 - State of Maryla		artment of He		ntal Hygier	2006	049
Physi		Decedent's Name (First, Middle, Last)     Chang Sun Pak				Date of Death Month	Day 1 2 Year	3. Time of Death
/Med Exam		a. Facility Name, (If not institution, give street and number)  Nary and General Hosp	ital	Abocity, Town, or L Baltime	ocation of Death	V	4c. County of Dea	
Funera Directo		5. Social Security Number  N/A  1	73 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	(Month, Day, Yea	ar) 1933	rthplace (State or Foreign ountry)
ylend			City, Town or Lo	ocation	<del></del>			10d. Inside City Limits
e Mar 38-f st	Director	Maryland Howard	E	llicott Ci	ty	····		1 ☐ Yes 2 ☑ No
with th		10e. Street and Number 3450 Ellicott Center Drive		10f. Zip Code 21043		10g.	Citizen of What C	ountry?
deeth with the Marylend ms 23a or 28a-f show rrivet be notified at	Funeral	11 Marital Status 12. Was Decedent Ever in	n U.S. 13.	Was Decedent of Hist	panic Origin? (Specif	y Yes or No-	14. Race - Am	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23s or 28s-1 show any injury or other treumstic event, the Maddical Examinat must be notified at	þ	Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	ĺ	If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	Specify:	an, etc.)	Black, Whi	Korean
15-0-15-0 n 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired)	ion inng most of working	16b	. Kind of Business	s/Industry
212 d withing giene.	ome	Elementary/Secondary (0-12) College (1-4or 5+)		ger of Fina	ance Compa	ıny F	inancing	3
Ind he file tal Hyg	Be	17. Father's Name (First, Middle, Last)		1	18. Mother's Name (F		len Sumame)	
ryla hould i d Meni d Meni d marke	2	Jong Woo Pak  19a, Informant's Name/Relationship (Type, Print)	19h Maili	ng Address (Street an	Bok Hee		ty or Town State	Zin Code)
Ma Mith an Mith an Treum		Sang Pak (Daughter)					-	y, MD 21043
of Hear			b. Place of Dispo		Date		Location - City of	
timent thent thent:		`4 Donation 5 □ Other (Specify)	Crestlav		4-4-2	.006 Ma	rriotts	ville, MD
Baar Important	X	21. Signature of Funeral Service Licensee	2 1		eral Homes Knolls Roa	d Columb	oia, Mary	land 21045
		23a. Part i. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final	leath. Do not en	ter the mode of dying,	such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death
Physicia: /Medica		disease or condition resulting in death)  Due to (or as a con	sequence of):	14mia				
Examine		Sequentially list conditions. b. Druba		nyocard	ial infa	retion		
) o iii	ulner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):	l				
execut n and ial-trar	Examiner	that initiated events c c Due to (or as a con:	sequence of):					
8760, Kerate be executed only sicien and the burial-transit	dical	d						
X 6(certific	/Med	IF FEMALE: 23c. If yes, outcome of pre	gnancy				23d. Date of de	livery
Cords, P.O. Box 6 wrequires that the death certifit been signed by the attending t should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	etal death 3[	Ectopic pregnancy Other (specify)			Month	Day Year
S, P, es that	by Pt	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause given	in Part I.			to the cause of death?
ord requir	eted							Probably 4 Denknown
Vital Rec	Completed					24a. Was an autopsy performed 1 Yes 2 1	prior to death?	utopsy findings available completion of cause of
ital	Be C	25. Was case referred to medical examiner?			26. Place of Death (0		40 10 10	2 2 110
of Vita Physicien: this certific	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2			4   Nursing Home	5 Residence		ecify)
ion of Naing Physith: «After this estumeral dir	atlon	27. Manner of Death  1 Matural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year	r) Injury	Work?	es 2 No	2. Describe now ii	ijary occurred	
Division of Vital Records, To the Hospital or Attending Physician: The law requires the Within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled in by the funeral director, page 2 should be	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office	28f	. Location (Street City or Town, St		Rural Route Number,
is Hospite 124 hours 16 Funere	Medical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, deal nination and/or in	h occurred at the time vestigation, in my opin	, date and place, and nion, death occurred	d due to the cause at the time, date a	n(s) and manner a and place, and du	s stated. e to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier		29c. License		29d. I	Date signed (Mon	nth, Day, Year)
		30. Name and address of person who completed cause of death (	Itom 22a\ /Tue-		03086	1	Pri) 1,2	-006
3		30 Shame and address of person who completed cause of death (	) C//	Marule	and Ge	neral	HOSDI	'tal
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Si	ignature	No			7	
Regis	urair	APR 0 5 2006	15 Agos	KIL				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Silver Spring

3. Time of Death

10d. Inside City Limits

P٨

State Registra Amend item #10g Per FH G854 4 Pentificate upf Death 1. Decedent's Name (First, Middle, Last)

Emanuel W. Pedersen 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number)

2006 March 30,

Reg. No.

7:05 4c. County of Death

3381 South Leisure World Blvd. 5. Social Security Number **Funeral** 

**Physician** 

/Medical

Examiner

6. Sex 1 M M 2 ☐ F 10a State 10b. County

7. Age (In yrs. last birthday) Days 101 Yrs

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea May 28, 1 Hours Min 1904

2. Date of Death

 Birthplace (State or Foreign Country) Denmark

220-40-3089 Director Usual Residence of Decedent

> 1 ☐ Yes 2 No 10g. Citizen of What Country?

Montgomery

United States Denmark

14. Race - American Indian Black, White, etc. Specify: White

Religion

16b. Kind of Business/Industry

20c. Location - City or Town, State

Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.

45 Years

23d. Date of delivery Day Month

Year

Approximate Interval Between Onset and Death

Acute

24a. Was an autopsy perform

24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2 ₩ No

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

29c. License number D16458

April 3, 2006

D

State

Thomas E. Dooley, M.D. 31. Date filed (Month, Day, Year)

/17904 Georgia Avenue, #304, Olney, Maryland 20832 32. Registrar's Signature

APH 0 5 2006

porte

death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Dep	partment of Health and Mertificate of Death	lental Hyg	iene 2006 10496	
	Physici		1. Decedent's Name (First, Middle, Last)  Joseph Donato Rotondo		2. Date of Death	Day Year 3. Time of Death 929 A	A.
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 201 Wagner Road	4b. City, Town, or Location of Death Bel Air	agric	4c. County of Death Harford	
I	Funeral Director		5. Social Security Number 151-12-6328 6. Sex 7. Age (In yrs. last birthda Yrs. Usual Residence of Decedent	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, July 30	Year) 9. Birthplace (State or Foreig Country) New Jersey	ın
	Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or	Location 1 Air		10d. Inside City Limit 1 ☐ Yes 2 🛭 N	
	with the	Direc	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours elter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinar must be notified at DDGs.	by Funeral Director	201 Wagner Road  11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No   Yes 2 □ No   Yes or Dates:	21015  3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1□ Yes 2√√2 No Specify:	ecify Yes or No- Rican, etc.)	U.S.A.  14. Race - American Indian, Black, White, etc.  Specify: white	
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ı	To the within to the comp	Me	29b. Signature and title of certifier  Denne La Linker MA DME	29c. License number	C C	9d. Date signed (Month, Day, Year)	
	4+1		30. Name and address of per in while completed cause of death (Item 23a) (Typ BERNALD J. YUKWA, M.A. DWE 7018 H	DOO 14 206  Print)  DABIND AVE BA	LTO Md,	21222	
	Sta Registi		31. Date filed (Month, Day, Year)  APR 0 5 2006	Coole	,		

DHMH 17 Rev 1/2001

Joseph Rotondo

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. Nb. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** March 29 Helen Sue Rosenstein 2006 3:00 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4273 Bright Bay Way Ellicott City Howard If Under 1 Year | If Under 24 Hrs.
Months Days Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) May 28,1942 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 戻 F Months 63 Yrs Connecticut Director 043-34-9522 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other then "naturel", or iteme 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Maryland Howard Ellicott City Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4273 Bright Bay Way 21042 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Depertment of Health and Mental Hygiene important: if I tem 27 is marked other then "reny injury or other traumatic anawas Elementary/Secondary (0-12) College (1-4or 5+) 4+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Rosen Mildred Beloff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Rosenstein Bright Bay Way Ellicott City, Maryland 21042 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 3-31-2006 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, Maryland 22. Name and Address of Facility
Witzke Funeral Homes, 1
5555 Twin Knolls Road 21. Signature of Funeral Service Licensee Inc. Columbia, Maryland 21045 Hadema 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adinoralinoma Breast - my fastation Cay H /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thal initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed the ettending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 %No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ascites Hnimin 1 Yes 2 No 3 Probably 4 Unknown Completed Malnotatio 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funerel Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30573 3-30-06 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NW MINFORD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - State of Maryland / Registrer	-	artment of <i>tificate of</i>				iene g. No.	16	104,98	
	Discosio i		Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day	Year .	3. Time of Death	
	Physici /Medic		Anita · DELLA - ROVERE					March	29	2006	7-20PM	
4	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town,		n of Death		4c. Cour	nty of Death		
			Howard General Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last by the second security Number)   7. Age (In yrs. last by the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second secon	nirth days	Colu	ımbia	er 24 Hrs.	8. Date of Birth		Howar	d lace (State or Foreign	
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	Be-f s	Director	Maryland Howard		olumbia						1 ☐ Yes 2 ☑ No	
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	eath v	eral	11. Marital Status 12. Was Decedent Ever in U.S.	13. \	_1		Origin? (Spec	ifv Yes or No-		ace - Americ	an Indian.	
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	N		30. Name and address of person who completed cause of death (Item 23a N.B. VELLANKI, 8850, COLUMBIY)	ı) (Турө. <b>А (с</b>	Print) PARI	CWAY	#3	os Col	LUMB	A M	0.21045-	
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Please Type or Print in Black Indelible Ink.	<b>Ensure All Copies Are Legible</b>

		1 - For State Registrar	State of Ma	aryland / Depa <i>Cer</i>	artment of Hertificate of L			giene Reg. No.	ÜĘ	10499		
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/Medi		ROBERT LEE RAN	DOLPH				POEL	Day	200%	12:15 AM		
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1241		30. Name and address of person who cor		ath (Item 23a) (Type, P		W	. ^					
10		AAMON J. CAMLUE			mes st	MARIM	ore m)	21	204			
Stat		31. Date filed (Month, Day, Year)	32. Registrar		4.0							
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				For State Registrar	State o	f Marylar		artment of F rtificate of		d Mental Hy	giene Reg. No.	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	10500
	F	September 1		1. Decedent's Name (First, Middle, L					2. Date of De	eath Day	_Year	3. Time of Death	
4		Physici /Medio		Joseph Fra			er			Apri.	L 1, 200	5	8:45 a <sup>M</sup>
•		Examin	er	4a. Facility Name (If not institution, g Atlantic G		4b. City, Town, or Location of Death Berlin			4c. County of Deal Worcest				
		Funeral Director		220-03-3605	Sex 1∰M 2□F	7. Age (In yrs.		Months Days		lin. (Month, D,	th year) 1920	Con	place (State or Foreign ntry) ryland
	1,700	and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or L	ocation					10d. Inside City Limits
		s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If Health and Mental Hygiene. Other traumatic avant, the Medical Examinar must be notified at	tor	Md. Worces	ter	В	erlin						1 ☐ Yes 2 ☐ No
١	0		Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cou	ntry?
	20	23a c		51 Moon Sh	ell Dr.			218	11			5.A.	
3	38 28	within 72 hours after dea ene. than "naturel", or Itama he Madical Exeminer m	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Amed Fo	2 No WW		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		(Specify Yes or No uerto Rican, etc.)	Blac	e - Americk, White,	
2	5-0036	hour tural	ed b	15. Decedent's	Year or D	2165:	16a, Dece	dent's Usual Occup	pation		16b. Kind of Bu		
7		hin 72 e. nn "nu Madia	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (	1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of d)	working			,
0	72	ed with	Con	12			F:	ireman			Baltin		City
0/	04 Maryland	12 should be filed within h and Menta! Hygiene. 7 Is marked other than fraumatic avant, the M	Be	17. Father's Name (First, Middle, La						Name (First, Middle	, Maiden Sumam	e)	
	ryla .	hould d Mer marke marlc	ပို	Frank Rosen  19a. Informant's Name/Relationship			19h Maili	nn Address /Street		a Walker	ner City or Town	State Zi	a Code
	S	od 2 s lith an 27 la i		Nancy Greenber		hter				, Owings			
	ē,	S 1 ar		20a. Method of Disposition		20b. i	Place of Dispe	osition (Name of matory or other pla	1	Date	20c. Location -		
5	E C	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other trac QDGS.		14 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec						Apr. 7, 2	006 Owin	igs N	Mills, Md.
360	Baltimore,			21. Signature of Friedral Service Licensee  22. Name and Address of Facility  Eckhardt Funeral Chapel, P.A. 21117  11605 Reisterstown Rd., Owings Mills, Md.  23a. Parm. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate									
6.7				23a. Parti. Enter the disease, or co shock, or heart failure. List on	mplications that of	caused the dea	th. Do not en	ter the mode of dyi	stersto ng, such as can	diac or respiratory a	wings Mi	. <del></del>	Approximate Interval Between
3		Physician		Immediate Cause (Final disease or condition	D	veum	once	1					Opset and Death
0		/Medical Examiner		resulting in death)	/	(or as a consec		1		1 6 - 27	_		t
1			20	Sequentially list conditions,	D	(or as a consec	L	www	u 1)	156718Z		_	
0			Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that intitated events c.									
32	oʻ	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to	(or as a consec	quence of):						
	8760	ate be hysici the bu	dicai	•	d								
2	9	certific nding pluse as t	/Med	IF FEMALE:	23c If yes ou	tcome of pregn	ancv				024 54	6 -4-15	
berg	.О. Вох	death e atte	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 Live t	oirth 2 ☐ Feta nant at time of c	al death 3	□Ectopic pregnanc □ Other (specify) _	у		Mo	e of deliventh	Pery Day Year
Rosen	ds, P	8 E 8	by	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	underlying cause gr	ven in Part I.		tobacco use cont Yes 2☑No	•	the cause of death?
	of Vital Records,	aw 2 s b	Completed							24a. Was auto perfi 1 □ Yes	ormed?	Were auto prior to co death?	opsy findings available ompletion of cause of
0	ita		Bec	25. Was case referred to medical					26. Place of	Death Check only			20.10
oseph	Ž	Physician: r this certific ral director,	To	examiner? 1 Yes 2, No			ER/Outpatie	III JUDON		g Home 5□ Res	idence 6 🗆 Oth	ar (Speci	fy)
3	~ -	Da 0 0	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occur	ed	
15	Division	Attending ir death. actor: After by the fune	ficat	2 Accident investigat 3 Suicide 6 Could not	be 200 Bloom	of Injury - At h	ome farm st	M 1	Yes 2 □No	28f Location	(Street and Numb	er or Rur	al Route Number,
1	Š	affor A	Certification:	4 Homicide determine	build	ing, etc. (Speci	fy)	reet, factory, office			wn, State)	37 07 7107	a, riodio rvambo,
1		To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun	Medical C	29a. Certifier 1 Certifying (Check only one)	eminer: On the b	e best of my kno asis of examina iner stated.	owledge, deat ation and/or in	th occurred at the ti	me, date and pl opinion, death o	ace, and due to the courred at the time,	cause(s) and ma date and place,	nner as s and due t	stated. to the cause(s)
		To th withir To th comp	M	29b. Signature and title of sertifier		3		29c. Licens		7	29d. Date signer	. /	
				June					1625		4/2		
	-			30. Name and address of person when Encuring CAST	o completed cau	se of death (Item	7032	Print)	Com	Cerer			
:	400	Sta Registi		31. Date filed (Month, Day, Year)  APR 0 5	- APK	ègistrar's Sign	k do	ale					

DHMH 17 Rev 1/2001